SOUTHEAST TEXAS
EAR, NOSE & THROAT

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Patient History

Name_____ DOB _____ Today's Date _____

Have or have had these conditions or symptoms (please circle):

Y N Frequently tired
Y N Psychiatric condition
Y N Swollen glands
Y N HIV
Y N Bleeding tendencies
Y N Blood disorder
Y N Blood clots
Y N Transfusions/reactions
Y N Liver:
Hepatitis/Jaundice/other
Y N Chest pain
Y N Tingling in arms/legs
Y N Kidney/bladder problems
Y N Weight loss
Y N Stomach/bowel problems
Y N Loss of appetite
Y N Current use of diet pills/injections
Y N Glaucoma
Y N Other eye problems
Y N Prior surgery with pins/rods/plates

Y N Sinus problems
Y N Chronic cough
Y N Hay fever/allergies
Y N Hoarseness
Y N Migraines or headache
Y N Sleep apnea, if yes: CPAP Y N
Y N Aneurysm
Y N Nervous system disorders:
Neuropathy/MS/Parkinson's
Y N Pneumonia
Y N Mitral valve prolapse
Y N Hiatal hernia
Y N Fainting spells
Y N Convulsions/epilepsy/seizures
Y N Drug abuse
Y N Alcohol abuse
Y N Allergic to latex
Y N Allergic to adhesives

Y N Respiratory problems:
Asthma/Emphysema
Shortness of breath
Y N Tuberculosis
Y N Thyroid problems
Y N Bronchitis
Y N History of numbness
Y N Diabetes
Y N Daily aspirin or blood thinners
Y N Stroke
Y N Heart murmur
Y N Pacemaker
Y N Irregular/fast heartbeat
Y N Heart attack
Y N High blood pressure
Y N Heart disease

Please List Current Physician(s): _____
_____

Medication Allergies/Type of Reaction: _____
_____
_____

List Previous Surgeries: _____
_____

Recent vaccines or any other information we should be aware of concerning your health?: _____
_____

Current Medications: (Include over-the-counter medications/vitamins/supplements, etc.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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Review of Systems/Symptoms (please circle)

CONSTITUTIONAL
Fever or Chills
Night sweats
Weight loss

EAR
Pain/swelling
Drainage
Fullness/pressure
Hearing loss
Tinnitus/ringing

GASTROINTESTINAL
Reflux/heartburn
Nausea/vomiting
Bowel changes/diarrhea
Stomach pain

PSYCHIATRIC
Anxiety
Depression

ALLERGIC/IMMUNOLOGIC
Frequent infections
Watery eyes
Hives

CARDIOVASCULAR
Chest pain
Irregular heartbeat
Heart disease

NOSE/SINUS
Nasal congestion
Drainage
Sneezing
Loss of smell
Snoring
Nosebleeds

MUSCULOSKELETAL
Weakness
Joint pain/swelling

ENDOCRINE
Fatigue
Nervousness

EYES
Vision changes
Blurred vision
Irritation/drainage

THROAT
Recurrent infections
Pain
Difficulty swallowing
Hoarseness
Loss of taste

SKIN/BREAST
Masses/lesions
Rash

HEMATOLOGIC/LYMPHATIC
Abnormal bleeding tendency/ bruise easily
Swollen glands

GENITOURINARY
Blood in urine
Difficulty urinating
Recurring Infections

RESPIRATORY
Shortness of breath
Cough
Wheezing

NEUROLOGICAL
Pain
Headaches
Numbness
Dizziness/balance problems

Social History

Do you drink alcoholic beverages? (circle) Daily Occasionally Rarely Never

Do you use recreational drugs? (circle) Daily Occasionally Rarely Never

Do you smoke? (circle) Daily Occasionally Rarely Never
If no, did you ever smoke? Y N When did you quit? _____

Females: Date of last menstrual period?_____ Are you pregnant now? Y N

Family History
_____ Heart disease _____ Bleeding disorder _____ Stroke _____ High blood pressure
_____ Diabetes _____ Cancer Relationship to you: _____ Part of the body affected: _____

The information provided is complete and accurate to the best of my ability.

_____
Patient/Guardian Signature

_____
Physician Signature