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 Cancer—site/type: _____

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
Y N Asthma/Emphysema
Y N 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
Y N Head injury

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 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? _____

Do you smoke? Y N _____ Packs/Day or _____ Smokeless? Duration _____ years
If no, did you ever smoke? Y N When did you quit? _____

Females: Last menstrual period?_____ Are you pregnant now? Y N

Family History
_____ Heart disease _____ Bleeding disorder _____ Stroke _____ High blood pressure
_____ Diabetes _____ Cancer Who? _____ Location? _____

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

_____ _____
Patient/Guardian Signature Physician Signature