HILLS E·N·T
I N S T I T U T E

Patient Health History

Date _____________

General Information (Please Print)

Patient Name _________________________________ Date of Birth ______ Height ______ Weight _______

Are you pregnant? ***(women only)*** Yes ____ No ____

What is the reason for today's visit? ____

Medication Allergies or Sensitivities ____

Do you take any blood thinning medications or Aspirin? Yes ___ No ___ If yes, please list: _______________

Medications: Please list all prescription and nonprescription medicines or supplements (or provide a list)

Medicine/Supplement	Dose	How Often
________________________	____________	____________
________________________	____________	____________
________________________	____________	____________
________________________	____________	____________
________________________	____________	____________
________________________	____________	____________

Past Surgical/Major Illness History - List as accurately as possible

Surgery/Illness	Date
____________________________	____________
____________________________	____________
____________________________	____________
____________________________	____________
____________________________	____________

Patient Medical History - Please check all that apply

	Yes	No	Please Explain
Anesthetic complications	___	___	____________________
Claustrophobia	___	___	____________________
Bleeding problems	___	___	____________________
Cancer	___	___	____________________
Skin changes	___	___	____________________
History of fever, chills or weight loss	___	___	____________________
Visual changes	___	___	____________________
Cardiovascular problems, i.e. heart attack, chest pain	___	___	____________________
Respiratory problems, i.e. asthma, wheezing	___	___	____________________
Gastrointestinal problems, i.e. bloody stools, ulcers	___	___	____________________
Genitourinary problems, i.e. painful, bloody urination	___	___	____________________
Musculoskeletal problems, i.e. arthritis	___	___	____________________
Neurological problems, i.e. stroke, seizures	___	___	____________________
Psychiatric problems, i.e. depression, anxiety	___	___	____________________
Endocrine problems, i.e. diabetes, thyroid disorder	___	___	____________________
Immune problems, i.e. AIDS, immune deficiencies	___	___	____________________

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Patient Health History

Patient Name ________________________________ Date ____________________

Ear, Nose and Throat History - Please check all that apply

___ Hearing aids: R ___ L ___ Both ___
___ Hearing loss
___ Ear pain
___ Frequent ear infections
___ Ringing in ear: R ___ L ___ Both ___

___ Nose bleeds
___ Chronic sinus infections
___ Sinus headaches
___ Snoring
___ Decreased sense of smell/taste

___ Change in voice
___ Heartburn
___ Frequent sore throat
___ Hoarseness
___ Balance disturbance (Vertigo)

Social History

Tobacco exposure-Yes / Tobacco exposure-No / Tobacco use / Smokeless ***(circle all that apply)*** Other: ____________________
Age began ______ Years smoked ______ Average pack per day ______ Age quit ______
Alcohol use? _____ Yes _____ No If yes, number of drinks per week _____________
Drug use? _____ Yes _____ No If yes, please describe: ____

Family Medical History - Have any of your family members had the following?

	Yes	No	Relationship	Please Explain
Diabetes	___	___	_______________	____
High blood pressure	___	___	_______________	____
Heart disease	___	___	_______________	____
Cancer	___	___	_______________	____
Hearing loss	___	___	_______________	____
Asthma	___	___	_______________	____
Stroke	___	___	_______________	____
Respiratory failure	___	___	_______________	____
Bleeding disorders	___	___	_______________	____
Anesthetic complications	___	___	_______________	____
Other inherited diseases	___	___	_______________	____

I certify this information is true to the best of my knowledge. I will notify you of any changes in the above information.

Patient/Guardian Signature ____ ***Date Signed*** ______________________