

# HILLS ENT

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)

<u>Medicine/Supplement</u>	<u>Dose</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Surgery/Illness</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____

### Patient Medical History - Please check all that apply

	<u>Yes</u>	<u>No</u>	<u>Please Explain</u>
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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Date \_\_\_\_\_

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

Hearing aids: R  L  Both        Nose bleeds       Change in voice  
 Hearing loss       Chronic sinus infections       Heartburn  
 Ear pain       Sinus headaches       Frequent sore throat  
 Frequent ear infections       Snoring       Hoarseness  
 Ringing in ear: R  L  Both        Decreased sense of smell/taste       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?

	<u>Yes</u>	<u>No</u>	<u>Relationship</u>	<u>Please Explain</u>
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 \_\_\_\_\_