HILLS E·N·T
INSTITUTE

Patient Health History

Date _____

General Information (Please Print)

Patient Name _____ Date of Birth _____ Height _____ Weight _____

Are you pregnant? ***(women only)*** Yes ____ No ____ Do you have an Advanced Directive?_____

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 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*** _____