NORTHWEST MEDICAL GROUP ENT
PATIENT HEALTH HISTORY

Full Name _____ **DOB** _____ **Height** _____ **Weight** _____

What is the main reason you are seeing the doctor today? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **Yes** ☐ **No** **If yes, please list below.**

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES:
Are you allergic to anything in the environment such as grass, dust, or food? ☐ **Yes** ☐ **No**
If yes, please indicate what you are allergic to. _____
Are you allergic to Latex? ☐ **Yes** ☐ **No** **Are you allergic to IV Contrast Dye?** ☐ **Yes** ☐ **No**

CURRENT MEDICATIONS:

(This includes prescription, over-the-counter and herbal medications)

Medication Name	Dosage	How often taken

Do you take Aspirin daily **Yes** ☐ **No** ☐ **Dose:**

TESTS AND IMMUNIZATIONS:
Are your immunizations up to date? ***(CHILDREN ONLY)*** ☐ **Yes** ☐ **No**

FAMILY HISTORY: **Do any of your family members have any medical conditions or illnesses?** **Yes** ☐ **No** ☐

RELATIONSHIP: **MEDICAL ILLNESSES:**
Mother: _____
Father: _____
Sister: _____
Brother: _____
Daughter: _____
Son: _____

SOCIAL HISTORY:
Have you ever used Tobacco in any form? **Yes** ☐ **No** ☐

Type of Tobacco	How Many Years	Year Quit
Packs of Cigarettes a day: ___		
Other: (list type) _____		

Do you consume Alcohol? **Yes** ☐ **No** ☐

Type of Alcohol	How Much	How Often

Do you use Recreational Drugs? Yes ☐ No ☐
Are you exposed to SecondHand Smoke? Yes ☐ No ☐

DO YOU CURRENTLY HAVE:

FEVER:	**Yes ☐**	**No ☐**
DOUBLE VISION:	**Yes ☐**	**No ☐**
DIFFICULTY HEARING:	**Yes ☐**	**No ☐**
RUNNY NOSE:	**Yes ☐**	**No ☐**
HOARSENESS:	**Yes ☐**	**No ☐**
HEADACHES:	**Yes ☐**	**No ☐**
CHEST PAIN:	**Yes ☐**	**No ☐**
SHORTNESS OF BREATH:	**Yes ☐**	**No ☐**
VOMITING:	**Yes ☐**	**No ☐**
BLEEDING PROBLEMS:	**Yes ☐**	**No ☐**
MUSCLE ACHES:	**Yes ☐**	**No ☐**
RASH:	**Yes ☐**	**No ☐**

SURGERIES AND HOSPITALIZATIONS:

Have you or any family member ever had any problems with anesthesia (being numbed or put to sleep)? Yes ☐ No ☐

If yes, please list the problems that occurred. _____

HAVE **YOU** EVER HAD ANY OF THE FOLLOWING SURGERIES? **CIRCLE** ANY APPLICABLE

EARS: **YEAR:**
EAR TUBES: RIGHT LEFT _____
OTHER EAR SURGERY: _____
NOSE AND SINUS:
NASAL POLYP REMOVAL _____
SINUS SURGERY _____
SEPTOPLASTY _____
OTHER NASAL SURGERY: _____
MOUTH AND THROAT:
ADENOIDECTOMY _____
TONSILLECTOMY _____
OTHER MOUTH OR THROAT SURGERY: _____
NECK:
PAROTID GLAND REMOVAL _____
SUBMANDIBULAR GLAND REMOVAL _____
THYROIDECTOMY (PARTIAL / TOTAL) _____
OTHER NECK SURGERY: _____
HEART AND BLOOD VESSEL:
HEART SURGERY _____
VASCULAR SURGERY _____
CANCER SURGERY: _____ _____
TYPE:

THORACIC: **YEAR:**
RESECTION OF LUNG TUMOR _____
OTHER LUNG SURGERY: _____
ABDOMINAL/ GENITOURINARY:
HERNIA REPAIR _____
GALLBLADDER REMOVAL _____
LIVER SURGERY _____
PANCREAS SURGERY _____
SPLEEN REMOVAL _____
APPENDECTOMY _____
COLON RESECTION _____
BARIATRIC SURGERY _____
PROSTATE SURGERY _____
HYSTERECTOMY _____
TUBAL LIGATION _____
OTHER ABDOMINAL/GENITOURINARY SURGERY:

BONE:
BACK SURGERY _____
OTHER BONE SURGERY: _____
BRAIN SURGERY: _____
OTHER SURGERY: _____

PAST HEALTH HISTORY: Have **YOU** ever been *DIAGNOSED* WITH/OR had any of the following problems/procedures?

ALLERGIC RHINITIS / HAY FEVER	**Yes ☐**	**No ☐**
ANEMIA/BLOOD DISORDER	**Yes ☐**	**No ☐**
ANEURYSM	**Yes ☐**	**No ☐**
ANXIETY DISORDER	**Yes ☐**	**No ☐**
ASTHMA	**Yes ☐**	**No ☐**
ATHEROSCLEROSIS	**Yes ☐**	**No ☐**
AUTOIMMUNE DISORDER	**Yes ☐**	**No ☐**
BLEEDING DISORDER	**Yes ☐**	**No ☐**
BOWEL PROBLEMS	**Yes ☐**	**No ☐**
CANCER	**Yes ☐**	**No ☐**
SPECIFY: _____		
CARDIAC ARRHYTHMIA / ATRIAL FIBRILLATION	**Yes ☐**	**No ☐**
CAROTID BLOCKAGE (Neck artery)	**Yes ☐**	**No ☐**
CHEMOTHERAPY	**Yes ☐**	**No ☐**
CONGENITAL CARDIAC DISORDER	**Yes ☐**	**No ☐**
CORONARY ARTERY DISEASE	**Yes ☐**	**No ☐**
CORONARY ARTERY STENT	**Yes ☐**	**No ☐**
DIABETES	**Yes ☐**	**No ☐**
DOWN SYNDROME	**Yes ☐**	**No ☐**
EAR PROBLEMS/DISORDERS	**Yes ☐**	**No ☐**
EMPHYSEMA	**Yes ☐**	**No ☐**
HEART DISEASE /CONGESTIVE HEART FAILURE	**Yes ☐**	**No ☐**

HEARTBURN / REFLUX/GASTROESOPHAGEAL REFLUX, (GERD)	**Yes ☐**	**No ☐**
HEPATITIS / LIVER DISEASE	**Yes ☐**	**No ☐**
HIV/AIDS	**Yes ☐**	**No ☐**
HYPERTENSION (High Blood Pressure)	**Yes ☐**	**No ☐**
KIDNEY DISEASE	**Yes ☐**	**No ☐**
MIGRAINES	**Yes ☐**	**No ☐**
MYOCARDIAL INFARCTION/ HEART ATTACK	**Yes ☐**	**No ☐**
NASAL POLYPS	**Yes ☐**	**No ☐**
NERVE DISORDER/DISEASE	**Yes ☐**	**No ☐**
NOSEBLEEDS	**Yes ☐**	**No ☐**
PACEMAKER	**Yes ☐**	**No ☐**
PULMONARY DISEASE / COPD	**Yes ☐**	**No ☐**
RADIATION THERAPY	**Yes ☐**	**No ☐**
RECURRENT EAR INFECTIONS	**Yes ☐**	**No ☐**
RECURRENT SINUSITIS	**Yes ☐**	**No ☐**
RECURRENT TONSILLITIS	**Yes ☐**	**No ☐**
SEIZURES	**Yes ☐**	**No ☐**
SKIN DISORDERS	**Yes ☐**	**No ☐**
SLEEP APNEA	**Yes ☐**	**No ☐**
STROKE	**Yes ☐**	**No ☐**
THYROID DISORDER/DISEASE	**Yes ☐**	**No ☐**