



Ottawa Shores E.N.T. Associates, P.C.
PATIENT HEALTH HISTORY

In order for us to provide you the best care, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be computerized; you are welcome to a copy if you wish.

Full Name _____ Male [] Female [] Race _____ Date of Birth _____

(Name of person completing form _____ and Relationship to Patient _____)

Pharmacy Preference (include location) _____

Reason For Visit _____ Referring Physician? _____

(TAB 1) Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)

[] No [] Yes If yes, please list below include dosages.

Table with 4 columns: Medication Name and Dosage, Problem being treated, Date of Prescription, Prescribing Doctor

(TAB 2) ARE YOU ALLERGIC TO ANY MEDICATIONS? [] No [] Yes If yes, please list below.

Table with 2 columns: Name of Medication, Type of Reaction

(TAB 3) Are you allergic to anything in the environment such as pollens, dust, food, etc.? [] No [] Yes

If yes, please indicate what you are allergic to. _____

Have you ever had an allergy test? [] No [] Yes----- If yes, was it a blood test [] or a skin test []

(TAB 4) Have you ever been DIAGNOSED with any major health problem? Including but not limited to:

- Cancer (type) [] No [] Yes If yes, when _____
Prostate enlargement [] No [] Yes If yes, when _____
Nose and Sinus:
Nasal Allergies [] No [] Yes If yes, when _____
Sinusitis [] No [] Yes If yes, when _____
Heart and Blood Vessels:
High Cholesterol [] No [] Yes If yes, when _____
High Blood pressure [] No [] Yes If yes, when _____
Lungs and Respiratory:
Emphysema/COPD [] No [] Yes If yes, when _____
Asthma [] No [] Yes If yes, when _____
Stomach and Digestive:
Reflux/GERD/Heartburn [] No [] Yes If yes, when _____
Hepatitis [] No [] Yes If yes, when _____
Ulcer [] No [] Yes If yes, when _____
Kidney/Genitourinary Problems:
Renal failure [] No [] Yes If yes, when _____
Mental & Emotional:
Depression [] No [] Yes If yes, when _____
Anxiety [] No [] Yes If yes, when _____
Glands, Hormones, and Sugar Control:
Diabetes [] No [] Yes If yes, when _____
Thyroid deficiency [] No [] Yes If yes, when _____
Thyroid excess [] No [] Yes If yes, when _____
Blood & Lymph Node problems:
Anemia [] No [] Yes If yes, when _____
Bleeding disorder [] No [] Yes If yes, when _____
Allergies, Immune & Infectious Problems:
HIV [] No [] Yes If yes, when _____
Infectious mononucleosis [] No [] Yes If yes, when _____

Have you ever been DIAGNOSED with any other major health problem not listed above? [] No [] Yes If yes please list diagnosis and year the diagnosis was made. _____

(TAB 5) SURGERIES AND HOSPITALIZATIONS

Have you been hospitalized for a medical problem before? [] No [] Yes

If yes, list hospitalizations, the reason for admission and the date. _____

Have you ever had surgery? [] No [] Yes

If yes, list any surgeries and when they were done. _____

Have you ever had any problems with anesthesia (being numbed or put to sleep)? [] No [] Yes [] N/A

If yes, please list what sort of problems. _____

(TAB 8) FAMILY HISTORY

Anesthesia Problems: Whom? _____
Ears:
Hearing Loss before age 20 Whom? _____
Hearing Loss after age 20 Whom? _____
Nose and Sinus:
Nasal Allergies Whom? _____
Heart and Blood Vessels:
Heart Disease Whom? _____
High Blood Pressure Whom? _____
Lungs and Respiratory:
Asthma Whom? _____

Lung Cancer Whom? _____
Skin &/or Breast:
Breast Cancer Whom? _____
Skin Cancer Whom? _____
Brain and Nervous:
Stroke Whom? _____
Blood & Lymph Node problems:
Bleeding/clotting problem Whom? _____
Other Whom? _____

(TAB 9) SOCIAL HISTORY

What is or was your occupation(s)? _____ Check here if you are retired

Have you ever used tobacco in any form? No Yes
If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Are you exposed to second hand smoke? No Yes
Is there a personal history of substance abuse? No Yes

Do you consume alcohol? No Yes
If yes, please complete the following:

Type of Alcohol	How Much	How often

If yes, please explain _____

(TAB 10) REVIEW OF SYSTEMS: Have you had or have you recently had any...

General health problems?

(fever, weight loss, problems sleeping, etc.) No Yes
If yes, please list _____

Head or Face problems?

(headache, face pain, etc.) No Yes
If yes, please list _____

Eye problems that are not correctable with glasses?

(double vision, glaucoma, cataracts, etc.) No Yes
If yes, please list _____

Ear problems?

(pain, drainage, hearing loss, ringing, dizziness, etc.) No Yes
If yes, please list _____

Nose&Sinus problems?(obstruction, etc.)

No Yes
If yes, please list _____

Mouth & Throat problems?

(frequent sore throat, mouth sores, hoarseness, etc.) No Yes
If yes, please list _____

Neck problems?

(lumps, masses, pain, swollen glands, etc.) No Yes
If yes, please list _____

Heart or circulation problems? (blacking out or fainting, bluish discoloration of lips or fingernails, chest pain, irregular heartbeat, swelling of legs feet and/or ankles, leg cramps, etc.)

No Yes
If yes, please list _____

Lung or respiratory problems?

(wheezing, shortness of breath, frequent cough, etc.) No Yes
If yes, please list _____

Stomach problems?

(pain, heartburn, nausea, vomiting, diarrhea, bleeding, etc.) No Yes
If yes, please list _____

Kidney bladder or gender related problems? (burning, bleeding, change in urinary pattern, problems passing urine, prostate problems, ovarian cysts, etc.)

No Yes
If yes, please list _____

Bone, Joint or Muscle Problems?

(painful joints, muscles, bone deformities, etc.) No Yes
If yes, please list _____

Skin or Breast problems?

(skin rash, sores tender nipples, etc.) No Yes
If yes, please list _____

Brain or Nervous system problems?

(seizures, numb areas, nerve problems, etc.) No Yes
If yes, please list _____

Mental or Emotional problems?

(depression, anxiety, suicidal thoughts, etc.) No Yes
If yes, please list _____

Problems bleeding freely, bruising excessively, or other blood problems.

No Yes
If yes, please list _____

Allergies or Frequent infections in different areas of your body?

No Yes
If yes, please list _____