Date ________________

M.A. ________________

Time In ______________

North Valley Ear, Nose, and Throat
PATIENT HISTORY

To Our Patients:
Thank you for completing the following confidential history form. It will help us greatly in the overall evaluation of your problem. We will develop your history further in a few minutes in the examining room. Until then and thereafter, if you have any questions of our staff, please do not hesitate to ask.

Name____ Age_____ Date of Birth_______________ Male / Female ☐
Last First Middle Initial

Referred to this office by: ______________________________ Primary Care Physician: ______________________

Specialists treating you: ____

For what problem did you come to see the provider today?____

____

____

____

____

List any recent x-rays, labs or tests related to your visit: (type, date, facility, doctor)______________________

____

Any past history of: (if YES, please check and elaborate briefly below. If NONE, check here ☐)

☐☐ Asthma ☐ Diabetes ☐ Heart Trouble ☐ High Blood Pressure ☐ Bleeding Disorder ☐ HIV

☐ COPD ☐ GERD ☐ Liver Trouble ☐ High Cholesterol ☐ Kidney Disease ☐ Other

Explain:____

List any previous surgeries:____

____

What PRESCRIPTION medications do you take and why?_____________________________________

____

____

____

What other NON-PRESCRIPTION (over the counter, herbal or homeopathic) medications do you take?______________

____

Are you allergic to any medications? ☐☐ Yes ☐ ☐ No If Yes, please explain ______________________________

____

Social History**:**

Occupation_________________________________ Do you live: ☐ Alone ☐ W/ Spouse ☐ W/ Family ☐ W/ Friends ☐ Assisted Facility

Do you smoke? ☐ ☐ Yes ☐ ☐ No, Have you ever smoked? ☐ Yes ☐ No How long?_______yrs. How much?______ packs/day

When did you quit smoking? _________________________ Any illicit drug use?__________________________

Do you drink caffeinated beverages? ☐ Yes ☐ ☐ No, How much? ________ drinks/day; Alcohol? ☐ Yes ☐ ☐ No How much? _________

Family History:	Age	Diseases/Conditions	Cause of Death
Father	________	________________________________	______________________
Mother	________	________________________________	______________________
Siblings	________	________________________________	______________________

Review of Systems:

Please check any of the following problems you are experiencing: **If none, please check here** ☐ ☐

General:	☐ Fever	☐ weight change	☐ fatigue	☐ night sweats	☐ appetite changes	
Skin:	☐ Skin growths	☐ rashes	☐ itching	☐ skin/nail/hair changes		
Lungs:	☐ Wheezing	☐ chronic cough	☐ coughing up blood			
Heart:	☐ Chest pain	☐ angina	☐ swelling of hands/feet			
Gastrointestinal:	☐ Heartburn	☐ diarrhea	☐ nausea/vomiting			
Neurology:	☐ Headaches	☐ fainting	☐ numbness	☐ weakness	☐ slurred speech	☐ migraines
Psychiatry:	☐ Nervousness	☐ anxiety	☐ depression			
Endocrine:	☐ Excessive thirst or urination		☐ cold/heat intolerance			
Hematology:	☐ Anemia	☐ blood clots	☐ HIV	☐ easy bruising/bleeding		
Other:	☐ Previous anesthesia problems					