CONNECTICUT EAR, NOSE & THROAT, SINUS & ALLERGY SPECIALIST, P.C.
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Diseases and Surgery of the Ear, Nose, & Throat, Endoscopic Sinus Surgery, Voice Evaluation
Head and Neck Surgery, Thyroid Surgery, Laser Surgery, Facial Plastic and Reconstructive Surgery
Allergy, Snoring, Apnea, Hearing Evaluation and Treatment, Vertigo and Balance Assessment and Treatment

PATIENT MEDICAL HISTORY FORM

NAME _____ **AGE** _____ **DOB**_____ **APPT DATE**_____

CHIEF COMPLAINT (Please describe the medical condition which brings you here today)

_____

CURRENT MEDICATIONS **DOSAGE** **FREQUENCY** **REASON**

_____

_____

_____

_____

_____

_____

(Please include any over-the-counter medications, vitamins, and holistic treatments.)

Are you pregnant? No Yes
Do you take aspirin or ibuprofen on a regular basis? No Yes (how much?) _____
Are you allergic to any medications? No Yes (which ones?) _____
If yes, please list type of reaction:_____

PHARMACY _____
(Name, street address, city, state, zip code)

MEDICAL HISTORY: Please circle responses, and describe as appropriate in the space provided.

DISEASE	**PATIENT'S HISTORY**			**FAMILY HISTORY**		
Asthma	No	Yes	_____	No	Yes	_____
Bleeding Disorder	No	Yes	_____	No	Yes	_____
Cancer	No	Yes	_____	No	Yes	_____
Diabetes (sugar)	No	Yes	_____	No	Yes	_____
Hearing Loss	No	Yes	_____	No	Yes	_____
Heart Disease	No	Yes	_____	No	Yes	_____
Heart Murmur	No	Yes	_____	No	Yes	_____
Hepatitis	No	Yes	_____	No	Yes	_____
High Blood Pressure	No	Yes	_____	No	Yes	_____
HIV	No	Yes	_____	No	Yes	_____
Lung Disease	No	Yes	_____	No	Yes	_____
MRSA	No	Yes	_____	No	Yes	_____
Thyroid Condition	No	Yes	_____	No	Yes	_____
Tuberculosis	No	Yes	_____	No	Yes	_____
Ulcer Disease	No	Yes	_____	No	Yes	_____
Other	No	Yes	_____	No	Yes	_____

CONNECTICUT EAR, NOSE & THROAT, SINUS & ALLERGY SPECIALISTS, P.C

NAME _____

PREVIOUS SURGERY

_____

_____

_____

_____

SOCIAL HISTORY

Tobacco No Yes Cigarettes Cigars Pipe _____ amount per day. _____ number of years.
Quit _____ years ago. Previous _____ amount per day. _____ number of years.

Alcohol No Yes rare occasional daily heavy abuse

Other _____

REVIEW OF SYSTEMS (Circle appropriate responses. If none apply, circle Neg for negative.)

Neg **CONSTITUTIONAL** chills fatigue weight loss fever
Neg **EYES** vision change double vision floaters tearing
Neg **NEURO** headache fainting tremors numbness

Neg **EARS** ear pain ear drainage dizziness vertigo fullness tinnitus decreased hearing
Neg **NOSE** sneezing sinus pain nasal drainage bleeding nasal congestion
Neg **MOUTH** sores pain loss of taste
Neg **THROAT** hoarseness difficulty swallowing painful swallowing sore throat lump

Neg **CARDIOVASCULAR** palpitations chest pain short of breath
Neg **RESPIRATORY** cough wheeze cough blood difficulty breathing breathing sounds
Neg **GI** indigestion stomach pain nausea vomiting diarrhea
Neg **SKIN** rash itching
Neg **ALLERGY** seasonal contact ingested food inhalation

Neg **GU** trouble urinating discharge blood in urine pain on urinating
Neg **MUSCULOSKEL** joint pain muscle aches muscle weakness limb swelling
Neg **PSYCHIATRIC** anxiety depression
Neg **ENDOCRINE** cold intolerance heat intolerance excessive thirst constant hunger
Neg **HEMATOLOGIC** bleeding disorder easy bruising

PATIENT (OR GUARDIAN) SIGNATURE _____