Washington Ear, Nose and Throat

Patient History Data Sheet

Name ______________________________________ DOB _________Age______ Date_____________

Past Medical History

Do you have, or have you ever had…….

Yes	No	Heart Disease (heart attack, angina, heart surgery, arrhythmia)	Yes	No	Stroke or TIA
			Yes	No	Migraine headaches
Yes	No	Diabetes (insulin, pills, diet control)	Yes	No	Seizure
Yes	No	Lung Disease (asthma, emphysema, chronic bronchitis)	Yes	No	Anxiety Disorder
			Yes	No	Depression
Yes	No	High blood pressure	Yes	No	Panic attacks
Yes	No	Thyroid problems	Yes	No	Arthritis
Yes	No	Gastroesophageal Reflux Disease (GERD)	Yes	No	Glaucoma
Yes	No	Kidney trouble	Yes	No	Macular degeneration
Yes	No	Cancer	Yes	No	Use alternative medicine (please list)
Yes	No	Liver problems			
Yes	No	Head trauma			Other medical conditions: ____________________________________
Yes	No	Obstructive Sleep Apnea			

Previous Surgeries
(list any prior surgical procedures):

Current Medications
(doses):

Allergies to Medications:

Social History

Occupation/Job: ____

Marital Status: Single_______ Married_______ Divorced_______ Widowed_______ Other________

Have you used tobacco products? □ Yes □ No If so, please explain: ____

Have you used alcohol products? □ Yes □ No If so, please explain: ____

Do you use: Medical Marijuana: □ Yes □ No CBD Oil: □ Yes □ No CBD Oil with THC: □ Yes □ No

Do you use caffeine? □ Yes □ No If yes, how many cups/day: ______________

Race:

____American Indian/Alaskan Native
____Asian
____Black / African American
____Native Hawaiian / Other Pacific Islander
____White / Caucasian
____Other: _________

Ethnicity:

____Not Hispanic or Latino
____Hispanic or Latino
____Other:_________

Language:

____English
____Spanish
____Other:__________________

Washington Ear, Nose and Throat

Name: ________________________________

Family History

Have any family members had the following diseases? If so, please circle and indicate which relative.

Heart Disease	Migraine	Mental Illness	Epilepsy
Diabetes	Thyroid	Voice Problems	Bleeds Easily
Hearing Loss	Stroke	Dizziness	Cancer

Malignant Hyperthermia/Anesthesia Complications

□ Other hereditary diseases that run in the family: ____

Review of Systems

Recently have you had any of the following symptoms or problems:

General

Yes No weakness or fatigue
Yes No recent weight loss

Eyes

Yes No blurred vision
Yes No double vision

Ear, Nose, Mouth and Throat

Yes No trouble hearing
Yes No tinnitus or ringing in ears
Yes No ear pain
Yes No ear infection or drainage
Yes No dizziness, vertigo, or unsteadiness
Yes No stuffy nose
Yes No sinus trouble
Yes No frequent nose bleeds
Yes No frequent sore throats
Yes No pain near teeth or mouth
Yes No hoarseness or voice change
Yes No difficulty with swallowing
Yes No lumps in neck
Yes No pain in the neck

Cardiovascular

Yes No heart trouble
Yes No palpitations
Yes No high blood pressure

Respiratory

Yes No cough
Yes No asthma or wheezing
Yes No shortness of breath

Hematologic

Yes No easy bruising or bleeding
Yes No anemia

Comments

Allergic

Yes No hay fever or dust/mold allergy
Yes No food sensitivity or intolerance
Yes No chemical sensitivity
Yes No latex allergy or sensitivity

Gastrointestinal

Yes No heartburn or acid reflux
Yes No nausea or vomiting
Yes No diarrhea
Yes No ulcers
Yes No frequent use of antacids

Genitourinary

Yes No kidney problems

Musculoskeletal

Yes No joint pain or stiffness

Integumentary

Yes No skin rashes

Neurological

Yes No headaches
Yes No numbness in face, legs, or arms
Yes No seizures
Yes No weakness of arms of legs
Yes No blackouts or fainting
Yes No trouble speaking
Yes No confusion or memory loss

Psychiatric

Yes No nervousness or increased stress
Yes No sleep problems
Yes No excessive moodiness or worry

Endocrine

Yes No thyroid trouble
Yes No diabetes

Comments

_______ROS, PMHx, FHx, SHx Completed by patient and reviewed by M.D. ______________________________
Physician