

**WILLAMETTE ENT PATIENT MEDICAL HISTORY FORM**

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  M  F

Weight \_\_\_\_\_ lbs. Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Are you pregnant?  Yes How many weeks? \_\_\_\_\_

Occupation \_\_\_\_\_ Pharmacy \_\_\_\_\_

Physician Referring for Consultation \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Chief complaint or ENT concerns today \_\_\_\_\_

If you have been seen/treated by an ENT previously, please list their name and contact information below:

\_\_\_\_\_

Have you had a recent CT/MRI/Xray or Hearing Test pertaining to today's visit? Where and when?:

CT/MRI/Xray:  Yes \_\_\_\_\_ Hearing Test:  Yes \_\_\_\_\_

Allergies to Medication	Reaction	Allergies to Medication	Reaction
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

**Other Allergies and Reactions**

- Adhesive Tape \_\_\_\_\_
- Iodine \_\_\_\_\_
- Skin Cleansing Solution \_\_\_\_\_
- Latex \_\_\_\_\_
- Seasonal/Environmental Allergies  Yes  No
- Other \_\_\_\_\_

If yes, please circle any that apply to your seasonal/environmental allergies:

- Grass  Weeds  Trees  Dust  Mold  Cats  Dogs

**List current medications with direction and dose:**

- 1. \_\_\_\_\_ 6. \_\_\_\_\_
- 2. \_\_\_\_\_ 7. \_\_\_\_\_
- 3. \_\_\_\_\_ 8. \_\_\_\_\_
- 4. \_\_\_\_\_ 9. \_\_\_\_\_
- 5. \_\_\_\_\_ 10. \_\_\_\_\_

Aspirin  dosage \_\_\_\_\_ Blood Thinner  dosage \_\_\_\_\_ Anti-Inflammatory drugs  dosage \_\_\_\_\_

**List any medical problems you are currently being treated for:**

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Previous ear, nose throat or neck surgeries and date performed:**

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

**All other previous surgeries and date performed:**

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Exercise:** Frequency \_\_\_\_\_ Type \_\_\_\_\_

**Tobacco Use:**  Never

- Current Type of Tobacco \_\_\_\_\_ Years Used \_\_\_\_\_ Amount per Day \_\_\_\_\_ Every tried to Quit? \_\_\_\_\_
- Former Type of Tobacco \_\_\_\_\_ Years Used \_\_\_\_\_ Amount per Day \_\_\_\_\_ Age Stopped? \_\_\_\_\_
- E-Cigarette Use Years Used \_\_\_\_\_ Amount per Day \_\_\_\_\_ Ever Tried to Quit? \_\_\_\_\_

Do you consume caffeine daily?  Yes  No Type \_\_\_\_\_ Frequency \_\_\_\_\_ Amount \_\_\_\_\_  
 Do you consume alcohol?  Yes  No Type \_\_\_\_\_ Frequency \_\_\_\_\_ Amount \_\_\_\_\_

**Patient Medical History**

Have you or any family member ever had an unusual reaction to anesthesia?  Yes  No  
 Who? \_\_\_\_\_ Reaction \_\_\_\_\_

Do you have a family history of malignant hyperthermia? Who? \_\_\_\_\_  Yes  No

Do you have a family history of a bleeding disorder? Who? \_\_\_\_\_  Yes  No

Do you have unusual bruising or bleeding from cuts, surgery or tooth extraction?  Yes  No

Do your personal convictions prohibit blood transfusions?  Yes  No

**Have you ever had the following disorders? Include year of onset:**

Disease or Disorder	Y	Disease or Disorder	Y	Disease or Disorder	Y
Chest Pain		Headaches		Angioedema/Hives	
Heart Disease		Migraines		HIV	
Heart Attacks		Multiple Sclerosis		Lupus	
High Blood Pressure		Parkinson's Disease			
High Cholesterol		Diabetes		Bladder Disorder	
Irregular Heartbeat		Thyroid Disorder		Enlarged Prostate	
Pacemaker				Kidney Failure	
Stroke		Anemia			
		Bleeding Disorder		Arthritis	
Asthma		Form Large Scars/Keloids		Fibromyalgia	
COPD		Cancer of:		Neck Disorder	
Pneumonia				Back Disorder	
Sleep Apnea		Hearing Impairment			
Use CPAP		Tinnitus/Ringing of Ears		Anxiety	
Tuberculosis		Vertigo		Bipolar Disorder	
Use Oxygen		Nose Bleeds		Depression	
		Snoring		Mental Disease	
Attention Deficit Disorder		TMJ		Psychiatric Care	
Autism		Visual Impairment			
Bell's Palsy				Born Pre-Mature	
Cerebral Palsy		Hepatitis/Liver Disorder		How many weeks?	
Seizures		Reflux/Heartburn		Shortness of Breath	
Dementia		Stomach Ulcers		Swelling of legs/ankles	

**Please tell us about some of your family history:**  I am adopted  I am a foster child

Check any that apply with the specified family member

Mother  Blood Disorder  High Blood Pressure  Allergies  Sleep Apnea  Cancer, type \_\_\_\_\_  
 Heart Disease  Hearing Impairment

Father  Blood Disorder  High Blood Pressure  Allergies  Sleep Apnea  Cancer, type \_\_\_\_\_  
 Heart Disease  Hearing Impairment

Sister  Blood Disorder  High Blood Pressure  Allergies  Sleep Apnea  Cancer, type \_\_\_\_\_  
 Heart Disease  Hearing Impairment

Brother  Blood Disorder  High Blood Pressure  Allergies  Sleep Apnea  Cancer, type \_\_\_\_\_  
 Heart Disease  Hearing Impairment

Daughter  Blood Disorder  High Blood Pressure  Allergies  Sleep Apnea  Cancer, type \_\_\_\_\_  
 Heart Disease  Hearing Impairment

Son  Blood Disorder  High Blood Pressure  Allergies  Sleep Apnea  Cancer, type \_\_\_\_\_  
 Heart Disease  Hearing Impairment

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_