



EAR, NOSE, and THROAT SPECIALISTS of WISCONSIN

HEALTH HISTORY FORM

Please answer all questions.

Patient Name: _____ Date: _____

Today's visit is for: _____

Height: _____ Weight: _____

I have had the following tests done already: (X-rays, lab tests) _____

The following treatments have been tried: _____

Medications / Medical History

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

MEDICAL HISTORY / CURRENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY, FILL IN ANY OTHERS)

- | | |
|---|---|
| <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Problems: _____
<input type="checkbox"/> Damaged Heart Valves: _____
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Asthma
<input type="checkbox"/> Infections/TB/Hepatitis/HIV _____
<input type="checkbox"/> Emphysema | <input type="checkbox"/> Bronchitis
<input type="checkbox"/> Thyroid Problems: _____
<input type="checkbox"/> Hyper / Hypo (circle) Thyroid
<input type="checkbox"/> Stomach/GI/Reflux: _____
<input type="checkbox"/> Cancer, type: _____
<input type="checkbox"/> Sleep Apnea: _____
<input type="checkbox"/> Kidney: _____
<input type="checkbox"/> _____ |
|---|---|

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____

SURGERIES

TYPE OF SURGERY	DATE

for FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)	
Conditions/Problems	Family Members affected and exact nature of problems
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Problems	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Malignant Hyperthermia (Anesthesia complications)	
<input type="checkbox"/> Hearing Loss Before Age 60	
<input type="checkbox"/> Bleeding/Clotting Disorder	
SOCIAL HISTORY / HABITS	
<input type="checkbox"/> Smoker: _____ packs/day <input type="checkbox"/> Non-smoker <input type="checkbox"/> Quit smoking in _____ <input type="checkbox"/> Occupation _____ <input type="checkbox"/> Smokeless Tobacco: _____ <input type="checkbox"/> I exercise regularly <input type="checkbox"/> I exercise rarely <input type="checkbox"/> I do not exercise <input type="checkbox"/> Smoke exposure _____ Alcohol use: <input type="checkbox"/> Yes (drinks/week: _____) <input type="checkbox"/> No <input type="checkbox"/> Pets _____ <input type="checkbox"/> I have traveled outside the United States in the past three months <input type="checkbox"/> Daycare _____	

REVIEW OF SYMPTOMS: Please mark the symptoms you've been having for the past month.			
<p>GENERAL</p> <input type="checkbox"/> weight gain <input type="checkbox"/> weight loss <input type="checkbox"/> loss of appetite <input type="checkbox"/> fever <input type="checkbox"/> weakness <input type="checkbox"/> night sweats <input type="checkbox"/> dry mouth <input type="checkbox"/> depression <input type="checkbox"/> anxiety <p>SKIN</p> <input type="checkbox"/> rash <input type="checkbox"/> dry/sensitive skin <input type="checkbox"/> hives <input type="checkbox"/> new/worrisome moles <input type="checkbox"/> jaundice <input type="checkbox"/> redness <input type="checkbox"/> swelling <input type="checkbox"/> itching <input type="checkbox"/> bruising <p>EYES</p> <input type="checkbox"/> decreased vision <input type="checkbox"/> eye drainage <input type="checkbox"/> blurry vision <input type="checkbox"/> eye itching <input type="checkbox"/> Glaucoma	<p>RESPIRATORY</p> <input type="checkbox"/> shortness of breath <input type="checkbox"/> chest tightness <input type="checkbox"/> cough <input type="checkbox"/> wheezing <p>ALLERGY</p> <input type="checkbox"/> runny nose <input type="checkbox"/> scratchy throat <input type="checkbox"/> itchy eyes <input type="checkbox"/> ear fullness <input type="checkbox"/> sinus congestion <input type="checkbox"/> sneezing <p>EAR/NOSE/THROAT</p> <input type="checkbox"/> congestion <input type="checkbox"/> cough <input type="checkbox"/> coughing blood <input type="checkbox"/> nosebleed <input type="checkbox"/> hearing loss <input type="checkbox"/> dizziness <input type="checkbox"/> ringing in ears <input type="checkbox"/> change in voice <input type="checkbox"/> sore throat <input type="checkbox"/> snoring <input type="checkbox"/> ear pain <input type="checkbox"/> ear drainage <input type="checkbox"/> swollen tonsils <input type="checkbox"/> difficulty swallowing	<p>CARDIOLOGY</p> <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> leg swelling <input type="checkbox"/> shortness of breath <p>GASTROENTEROLOGY</p> <input type="checkbox"/> nausea <input type="checkbox"/> heartburn <input type="checkbox"/> history of having colon polyps <input type="checkbox"/> black tarry BM <input type="checkbox"/> vomiting <input type="checkbox"/> abdominal pain <input type="checkbox"/> diarrhea <p>MUSCULOSKELETAL</p> <input type="checkbox"/> joint stiffness <input type="checkbox"/> leg cramps <input type="checkbox"/> joint pain <input type="checkbox"/> joint swelling <input type="checkbox"/> back pain <input type="checkbox"/> neck pain <input type="checkbox"/> jaw pain	<p>NEUROLOGY</p> <input type="checkbox"/> headache <input type="checkbox"/> tingling/numbness <input type="checkbox"/> seizures <input type="checkbox"/> memory loss <input type="checkbox"/> problems walking <input type="checkbox"/> tremors/shaking <p>BLOOD/LYMPH</p> <input type="checkbox"/> swollen glands <input type="checkbox"/> fatigue <input type="checkbox"/> loss of appetite <input type="checkbox"/> easy bruising <p>ENDOCRINE</p> <input type="checkbox"/> fatigue <input type="checkbox"/> excessive sweating <input type="checkbox"/> excessive thirst <input type="checkbox"/> excessive urination <input type="checkbox"/> sleep problems <input type="checkbox"/> heat intolerance <input type="checkbox"/> cold intolerance <input type="checkbox"/> lump in neck or thyroid

Provider initials: _____ **Date:** _____