Name:
DOB:
Chart:
Age:
Date:

Ō·tō·laryn·gol'ō·gy Associates
ENT & Face, Head & Neck Plastic Surgery
www.otolaryn.com

HEALTH HISTORY DATA SHEET
(Complete this form in ink) **Please Print**

Provider _____ HEIGHT _____
WEIGHT _____

FAMILY PHYSICIAN _____

CHECK (√) BELOW ANY ILLNESSES YOU HAVE HAD.

- ☐ Allergies
- ☐ Asthma
- ☐ Bleeding Tendencies
- ☐ Bronchitis
- ☐ Cancer - Tumors
  Type_____
- ☐ Chicken Pox
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eye Disease
- ☐ Gastroesophageal Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
  Type_____
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Neuritis
- ☐ Obstructive Sleep Apnea
- ☐ Osteoarthritis
- ☐ Pancreatitis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcers (Leg)
- ☐ Ulcers (Duodenal)

List Other Illnesses
_____
_____
_____
_____
_____

MEDICATIONS

Are you currently taking any medications? ☐ Yes ☐ No
Please Print List Below

_____
_____
_____
_____

Are you currently taking any vitamins, herbal supplements or over the counter medications? ☐ Yes ☐ No **Please Print List Below**

_____
_____
_____
_____

OPERATIONS **Please Print**

TYPE	MONTH - YEAR	NAME OF HOSPITAL

FRACTURES **Please Print**

ALLERGIES CHECK (√) BELOW IF YOU ARE ALLERGIC TO:

- ☐ Penicillin
- ☐ Sulfa
- ☐ Codeine
- ☐ Demerol
- ☐ Aspirin
- ☐ Morphine
- ☐ Latex

Please Print Other Drug Allergies Not Listed On The Left _____
_____
_____
_____

Name:
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FAMILY HEALTH HISTORY DATA SHEET Physician: _____

FAMILY HISTORY (CHECK √ BELOW IF ANY OF THE CONDITIONS HAVE OCCURRED ON EITHER SIDE OF PATIENT'S FAMILY)

☐ Allergies
☐ Bleeding Tendencies
☐ Blood Disease
☐ Bone Disease
☐ Cancer or Tumors
☐ Cardiovascular Disease (Heart)
☐ Congenital Deformities
☐ Diabetes
☐ Gastrointestinal Disease
☐ Kidney Disease
☐ Mental Disease
☐ Pulmonary Disease
☐ Thyroid Disease
☐ Tuberculosis

List Any Other Illnesses
_____
_____
_____
_____
_____
_____
_____

Do you have a pacemaker? ☐ Yes ☐ No

Are you HIV positive? ☐ Yes ☐ No

Smoking Status: ☐ Never Smoker ☐ Current every day smoker ☐ Current someday smoker ☐ Former smoker
☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Smoker, current status unknown
☐ Unknown if ever smoked Start Date: _____ Quit Date: _____

Do you use alcohol? ☐ Yes ☐ No Amount per day _____

Do you use illegal substances? ☐ Yes ☐ No

Have you or anyone in your family had problems with anesthesia? ☐ Yes ☐ No

ROS (CHECK √ BOX IF YOU HAVE HAD THESE SYMPTOMS IN THE PAST YEAR)

- Constitutional: ☐ Weight Loss ☐ Fatigue ☐ Fever
- Eyes: ☐ Double or Blurry Vision ☐ Blindness ☐ Red Eyes
- Cardiovascular: ☐ Chest Pain ☐ Shortness of Breath on Exertion ☐ Cyanosis ☐ Ankle Edema ☐ Frequent Urination at Night
- Respiratory: ☐ Shortness of Breath ☐ Cough ☐ Coughing Blood ☐ Wheezing ☐ Use Oxygen
- GI: ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting ☐ Vomiting Blood ☐ Diarrhea ☐ Indigestion
- GU: ☐ Blood in Urine ☐ Burning ☐ Urinary Infections
- Musculoskeletal: ☐ Muscle Weakness ☐ Pain ☐ Tenderness ☐ Joint Swelling
- Skin: ☐ Rash ☐ Lumps ☐ Sores ☐ Loss of Hair
- Neuro: ☐ Headaches ☐ Blackouts ☐ Paralysis ☐ Numbness ☐ Head Injury
- Psychiatric: ☐ Nervousness ☐ Anxiety ☐ Memory Loss ☐ Sleep Disturbances
- Hematology/Lymphatic: ☐ Anemia ☐ Bruise Easy ☐ Enlarged Lymph Nodes
- Endocrine: ☐ Excessive Thirst ☐ Intolerance of Heat or Cold ☐ High Blood Sugar
- Allergy/Immunologic: ☐ Inhalant or Food Allergy ☐ Itchy ☐ Frequent Infections

Have you ever taken Cortisone? ☐ Yes ☐ No

☐ Orally ☐ Injection

If yes, Month _____ Year _____

Please Print
Month _____ Year _____
Month _____ Year _____

VACCINATIONS (Please select the ones you have had)

☐ Mumps ☐ Tetanus ☐ Rubella ☐ Influenza
☐ Pneumococcal ☐ Hepatitis

Patient Signature _____