

SOUTHERN CRESCENT ENT MEDICAL HISTORY

Name _____

Date of Birth _____

Today's Date _____

Family Doctor _____

Referred by: _____

Height: _____ Weight: _____

Reason for today's visit _____

MEDICATIONS

NAME	AMOUNT	REASON
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

DRUG ALLERGIES

	NAME	TYPE OF REACTION
1)		
2)		
3)		
4)		

ENVIRONMENTAL ALLERGIES

previous allergy shots yes no

Please list

PAST SURGERIES

DATE

1)
2)
3)
4)
5)

SOCIAL HISTORY

Occupation _____

Cigarettes never yes packs per day _____ years _____ quit _____

Cigars never yes # per day _____ years _____ quit _____

Chewing tobacco never yes how many years _____ quit _____

Alcohol never occasional frequent heavy amount _____

Caffeine none yes amount/day _____ how long _____

Recreational drugs none yes amount _____

SOUTHERN CRESCENT ENT MEDICAL HISTORY PAGE 2

Name _____

Date _____

PAST MEDICAL AND FAMILY HISTORY FAMILY

Nose and sinus

Snoring/sleep apnea	father	mother	brother	sister
Nasal allergies	father	mother	brother	sister
Hearing loss	father	mother	brother	sister

Heart and Vascular

High blood pressure	father	mother	brother	sister
Heart disease/attack	father	mother	brother	sister

Lungs and Respiratory

Asthma	father	mother	brother	sister
Tuberculosis	father	mother	brother	sister
COPD	father	mother	brother	sister

Stomach and Digestive

Heartburn/reflux	father	mother	brother	sister
Stomach ulcer	father	mother	brother	sister
Hepatitis	father	mother	brother	sister

Kidney and Gender

Kidney Failure	father	mother	brother	sister
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Mental/Emotional

Depression	father	mother	brother	sister
Anxiety	father	mother	brother	sister

Glands, Hormones, Sugar Control

Diabetes	father	mother	brother	sister
Insulin dependent	father	mother	brother	sister
Thyroid excess	father	mother	brother	sister
Thyroid decrease	father	mother	brother	sister

Blood and Lymph Node Problems

Clotting difficulty	father	mother	brother	sister
Anemia	father	mother	brother	sister

Neurologic

Seizures	father	mother	brother	sister
Stroke	father	mother	brother	sister

Cancer (type)_____	_____	father	mother	brother	sister
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SOUTHERN CRESCENT ENT MEDICAL HISTORY PAGE 3

Name _____

Date _____

REVIEW OF SYSTEMS

CONSTITUTIONAL

Weight loss yes no
Weight gain yes no
Fevers/chills yes no
Night sweats yes no

EAR, NOSE, THROAT

Blurred/double vision yes no
Glaucoma yes no
Hearing loss yes no
Ringing in ears yes no
Balance difficulty yes no
Dentures yes no
Decreased sense smell yes no
Dry mouth yes no
Difficulty swallowing yes no
Daytime sleepiness yes no

CARDIOVASCULAR

Chest pain yes no
Irregular heartbeat yes no
Swelling hands/feet yes no

RESPIRATORY

Shortness of breath yes no
Wheezing/Asthma yes no
Chronic cough yes no

GASTROINTESTINAL

Nausea/vomiting yes no
Difficulty swallowing yes no
Heartburn yes no
Abdominal pain yes no
Hemorrhoids yes no
Constipation yes no
Diarrhea yes no

GENITOURINARY

Blood in urine yes no
Kidney stones yes no
Painful urination yes no
Pregnant yes no

SKIN

Itching yes no
Changes in lesions yes no

NEUROLOGICAL

Frequent headaches yes no
Convulsions/seizures yes no
Numbness/tingling yes no
Loss of consciousness yes no
Downs Syndrome yes no
ADHD yes no

ENDOCRINE

Excessive thirst yes no
Heat intolerance yes no
Cold intolerance yes no
Thyroid disease yes no
Hormone imbalance yes no

PSYCHIATRIC

Depressed mood yes no
Anxiety yes no
Difficulty sleeping yes no

HEMATOLOGIC/LYMPHATIC

Bruise easily yes no
Bleeding easily yes no
Slow healing yes no
Enlarged glands yes no