Scotch Institute of Ear Nose & Throat
a division of Select Physicians Alliance, PL

PATIENT MEDICAL HISTORY

Please PRINT clearly in ink.

Patient Name:_____ **Date of Birth:** _____

Primary reason for today's visit: _____

Allergies (*write "no" if none):*_____	Current Medications *(write "no" if none):* _____	Age:_____
_____	_____	Height:_____
_____	_____	Weight:____
_____	_____	

Check all that apply:

Other Medical Conditions

- ❑ High Blood Pressure
- ❑ Bleeding Disorder
- ❑ Glaucoma
- ❑ Diabetes
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Sleep Apnea
- ❑ Asthma
- ❑ Cancer (of_____)
- ❑ Poor Circulation
- ❑ Heart Disease
- ❑ Other: _____

Check all that apply:

Past Surgeries

- ❑ Tonsillectomy
- ❑ Adenoidectomy
- ❑ Thyroidectomy
- ❑ Ear Surgery
- ❑ Sinus Surgery/Turbinate Surgery
- ❑ Nasal Septoplasty
- ❑ Carotid Artery Surgery
- ❑ Ear Tubes
- ❑ Pacemaker
- ❑ Heart Bypass / Valve
- ❑ Other: _____

Check all that apply:

Family History of Illness

- ❑ High Blood Pressure
- ❑ Bleeding Disorder
- ❑ Glaucoma
- ❑ Diabetes
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Hearing Loss
- ❑ Vertigo
- ❑ Cancer (of_____)
- ❑ Poor Circulation
- ❑ Heart Disease
- ❑ Other: _____

How often do you use Alcohol?

- ❑ Never
- ❑ Occasionally
- ❑ Daily: How Much ?

*Did you **ever** chew Tobacco?*

- ❑ Never did
- ❑ Yes
- ❑ Quit: When?

*Did you **ever** Smoke?*

- ❑ Never did
- ❑ Yes: ___ packs per day for ___ years
- ❑ Quit: When?

Review of Systems: Do you have any of these symptoms? Please check *yes* or *no* to each item…

		Yes	No
General	fever	❑	❑
	weight loss	❑	❑
	night sweats/chills	❑	❑
Ear, Nose & Throat	ear pain or itch	❑	❑
	dizziness	❑	❑
	nasal congestion	❑	❑
	ear drainage	❑	❑
	loss of smell	❑	❑
	throat pain	❑	❑
	hearing loss	❑	❑
	sinus pressure	❑	❑
	hoarseness	❑	❑
	ringing in ears	❑	❑
	nasal drainage	❑	❑
	snoring	❑	❑
Cardiac	chest pain when walking	❑	❑
	swollen ankles	❑	❑
	blackouts	❑	❑
Lung	cough	❑	❑
	shortness of breath	❑	❑
	blood in sputum	❑	❑
Endocrine	excessive sleepiness	❑	❑
	excessive thirst	❑	❑
	in ability to sleep	❑	❑
Heme/L	swollen glands	❑	❑
	bleeding problems	❑	❑
	blood transfusions	❑	❑
Allergy	sneezing	❑	❑
	post-nasal drip	❑	❑
	history of allergy shots	❑	❑
Eyes	dry eyes	❑	❑
	double vision	❑	❑
	excessive tears	❑	❑
Muscle	neck pain	❑	❑
	joint pains	❑	❑
	pain in jaw with chewing	❑	❑
Neuro	numbness	❑	❑
	paralysis/weakness	❑	❑
	headache	❑	❑
Psychiatric	depression	❑	❑
	anxiety	❑	❑
	memory loss	❑	❑
Skin	rash	❑	❑
	ulcers/growths	❑	❑
	discoloration	❑	❑
GI	heartburn	❑	❑
	difficulty swallowing	❑	❑
	nausea	❑	❑
GU	difficulty urinating	❑	❑
	blood in urine	❑	❑
	might you be pregnant now	❑	❑

Patient (or Guardian) Signature: _____ Date: _____

Physician Signature: _____ Date: _____