

**Ear, Nose and Throat Associates  
of Springfield**

**MEDICAL HISTORY FORM**

( ) Initial Hx

( ) Updated Hx

1. Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Reason for visit: \_\_\_\_\_

3. Do you have now, or have you ever had: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

a. Diabetes Mellitus ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Treatment: diet control \_\_\_\_\_ oral agents \_\_\_\_\_ Insulin \_\_\_\_\_

Medical complications: renal \_\_\_\_\_ neuropathy \_\_\_\_\_ vascular \_\_\_\_\_ other \_\_\_\_\_

b. Heart attack ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Angina or chest pain ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Heart failure ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Irregular or rapid heart beat ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Cardiac pacemaker inserted ..... YES \_\_\_\_\_ NO \_\_\_\_\_

c. High blood pressure ..... YES \_\_\_\_\_ NO \_\_\_\_\_

d. Stroke ..... YES \_\_\_\_\_ NO \_\_\_\_\_

e. Anemia ..... YES \_\_\_\_\_ NO \_\_\_\_\_

f. Asthma ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Emphysema and/or bronchitis ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Pneumonia ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Tuberculosis ..... YES \_\_\_\_\_ NO \_\_\_\_\_

g. Liver disease or jaundice ..... YES \_\_\_\_\_ NO \_\_\_\_\_

h. Stomach or duodenal ulcer ..... YES \_\_\_\_\_ NO \_\_\_\_\_

i. Kidney disease or stones ..... YES \_\_\_\_\_ NO \_\_\_\_\_

j. Arthritis (type) ..... YES \_\_\_\_\_ NO \_\_\_\_\_

k. Cancer or tumor ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Type, location, and date \_\_\_\_\_

Treatment given \_\_\_\_\_

l. Thyroid disease ..... YES \_\_\_\_\_ NO \_\_\_\_\_

m. Seizures or nervous condition ..... YES \_\_\_\_\_ NO \_\_\_\_\_

n. Varicose veins or blood clots in legs ..... YES \_\_\_\_\_ NO \_\_\_\_\_

o. Bleeding disorders ..... YES \_\_\_\_\_ NO \_\_\_\_\_

p. Transfusions of blood or plasma ..... YES \_\_\_\_\_ NO \_\_\_\_\_

q. AIDS, ARC, or HIV positive test ..... YES \_\_\_\_\_ NO \_\_\_\_\_

r. Other medical problems ..... YES \_\_\_\_\_ NO \_\_\_\_\_

4. Are you allergic to any medications or foods? .... YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please describe substance(s), with date and type of reaction:

\_\_\_\_\_  
\_\_\_\_\_

5. Do you smoke? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

6. Do you drink alcohol? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

7. What medications do you take regularly? Please give name(s) and dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did you last use aspirin or ibuprofen (motrin, advil) in any form? \_\_\_\_\_

8. Have you had any previous Ear, Nose, or Throat surgery or injuries? YES\_ NO  
If yes, please give name(s) or operation(s) or injuries and date(s):

\_\_\_\_\_  
\_\_\_\_\_

9. What other operations have you had? Please give type(s) and date(s):

\_\_\_\_\_  
\_\_\_\_\_

10. Among your blood relatives, is there a history of any of the following:

- a. Hearing loss or Meniere's Disease..... YES\_\_\_ NO \_\_\_
- b. Diabetes mellitus ..... YES\_\_\_ NO \_\_\_
- c. High blood pressure ..... YES\_\_\_ NO \_\_\_
- d. Heart disease ..... YES\_\_\_ NO \_\_\_
- e. Tumor or cancer ..... YES\_\_\_ NO \_\_\_
- f. Bleeding disorder ..... YES\_\_\_ NO \_\_\_
- g. Thyroid disease ..... YES\_\_\_ NO \_\_\_

11. Please give the name, address and phone number of your primary care doctor.

\_\_\_\_\_, M.D.  
\_\_\_\_\_  
\_\_\_\_\_ Telephone ( ) \_\_\_\_\_

12. How were you referred to our office?

Physician            Friend \_\_\_\_\_ Physician referral line \_\_\_\_\_  
Relative            Other \_\_\_\_\_

13. Please give the name, address and telephone number of the physician, family member or friend who referred you to our office.

\_\_\_\_\_, M.D.  
\_\_\_\_\_  
\_\_\_\_\_ Telephone ( ) \_\_\_\_\_

(Patient's signature)

(Date)

(Reviewed by Physician)