

**Ear, Nose and Throat Surgeons
of Western New England LLC
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? _____

Name _____

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)