EAR, NOSE & THROAT ASSOCIATES of Corpus Christi

Patient Name: _____ Birthdate: ____/____/____ Date: ____/____/____

PATIENT HISTORY

Have you ever had or do you have . . .

- ❑ Alcoholism
- ❑ Anemia
- ❑ Angina / Heart Attack
- ❑ Arthritis
- ❑ Asthma / Hay Fever
- ❑ Birth Defects
- ❑ Bladder Disease
- ❑ Bleeding Disorder
- ❑ Cancer: _____
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Failure
- ❑ High Blood Pressure
- ❑ HIV / AIDS
- ❑ Kidney Disease
- ❑ Liver Problem
- ❑ Lung Problem
- ❑ Mental Illness
- ❑ Stroke
- ❑ Thyroid Problem
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Hepatitis
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

Drug Allergies?

Current Medications?

Surgeries and Injuries?

Chief Complaint:

FAMILY HISTORY

Has anyone in your family had . . .

- ❑ Alcoholism
- ❑ Anemia
- ❑ Angina / Heart Attack
- ❑ Arthritis
- ❑ Asthma / Hay Fever
- ❑ Birth Defects
- ❑ Bladder Disease
- ❑ Bleeding Disorder
- ❑ Cancer: _____
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Failure
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Liver Problem
- ❑ Lung Problem
- ❑ Mental Illness
- ❑ Stroke
- ❑ Thyroid Problem
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

SOCIAL HISTORY

Occupation: _____ Retired? ❑ Yes ❑ No

Do you . . .

- ❑ Exercise Regularly
  - Type: _____
  - How Often: _____
- ❑ Use Alcohol
  - Beer / Wine / Liquor
  - How Often: _____
- ❑ Use Tobacco
  - Cigarettes / Cigars / Pipe
  - Snuff / Chew Tobacco
- ❑ Use Drugs
  - Marijuana / Heroin
  - Cocaine / LSD / Crack

Is there anything that would prevent you from receiving a blood transfusion? Yes ☐ No ☐

If necessary, do you consent for a BLOOD TRANSFUSION? Yes ☐ No ☐

PATIENT HISTORY

Do you consider yourself generally: ❑ Healthy ❑ Not Healthy ❑ Other: _____

Have you ever experienced or are you experiencing any of the following: *(please check all that apply)*

Eyes	❑ Blurred Vision	❑ Painful Eyes ❑ Other: _____	❑ Irritation from Light ❑ None
Ears, Nose, Throat & Mouth	❑ Itching ❑ Rhinitis (Runny Nose) ❑ Bruxism (Grinding Teeth) ❑ Pressure in Ears	❑ Nose Blocked ❑ Sores in Mouth ❑ Difficulty Swallowing ❑ Other: _____	❑ Post Nasal Drip ❑ Teeth Hurt ❑ Painful Swallowing ❑ None
Cardiovascular (Heart)	❑ Palpitations / Fluttering of Heart	❑ Pain in Chest ❑ Other: _____	❑ Shortness of Breath While Exercising ❑ None
Respiratory (Lungs)	❑ Wheezing	❑ Shortness of Breath While Sitting ❑ Other: _____	❑ Cough ❑ None
Gastrointestinal (Stomach)	❑ Constipation ❑ Reflux	❑ Diarrhea ❑ Other: _____	❑ Pain ❑ None
Genitourinary	❑ Hesitation when Urinating	❑ Urination at Night ❑ Other: _____	❑ Pain when Urinating ❑ None
Musculoskeletal	❑ Soreness	❑ Weakness ❑ Other: _____	❑ Cramping ❑ None
Integumentary (Skin)	❑ Itchy Skin ❑ Dry Skin	❑ Lesions on Skin ❑ Other: _____	❑ Bleeding ❑ None
Neurological (Nerves)	❑ Twitch ❑ Abnormal Movements	❑ Ringing in Ears ❑ Other: _____	❑ Dizziness / Vertigo ❑ None
Psychiatric	❑ Mood Swings ❑ Depression	❑ Situational Stress ❑ Other: _____	❑ Change ❑ None
Endocrine	❑ Hot Flashes ❑ Cold	❑ Hair Loss / Growth ❑ Other: _____	❑ Heat ❑ None
Hematologic / Lymph Nodes	❑ Bleeding Easily	❑ Night Sweats ❑ Other: _____	❑ None
Allergic / Immunologic	❑ Sneezing	❑ Eye Irritation ❑ Other: _____	❑ Reactions ❑ None