Patient Health History

Geneva Woods
Ear, Nose & Throat

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____

Occupation _____ Weight _____

Name of physician requesting this consultation _____

Past History

Please list any prior major illnesses, chronic diseases, syndromes, or conditions and/or injuries:

_____

_____

_____

Surgeries/Hospitalizations ❍ None	Year	Complications

Have you ever had problems with anesthesia? ❍ Yes ❍ No

Current Medication(s), including aspirin ❍ None	Dose	Frequency

List any allergies/reactions to medications, anesthetics or materials: ❍ None

_____

_____

Family History:

Do you have a family history of trouble with anesthesia? ❍ Yes ❍ No

Do you have a family history of easy bleeding? ❍ Yes ❍ No

Social History:

Do you smoke?

❍ No, I have never smoked.

❍ Yes, I smoke _____ packs of cigarettes per day for _____ years.

❍ No, I quit _____ years ago. At the most I've smoked _____ packs per day for _____ years.

❍ Yes, I smoke cigars or a pipe.

❍ Chewing tobacco? _____ Can(s) per _____

❍ Exposed to second-hand smoke?

Do you drink alcohol?

❍ No, never (or rarely)

❍ No, but I used to. How much? _____

❍ Yes ❍ Daily ❍ 1 or more times a week ❍ 1 or more times a month. How much? _____

Review of Systems
Are you currently, or have you had problems with:

Constitutional

Weight gain	❍ Yes	❍ No
Weight loss	❍ Yes	❍ No
Night sweats	❍ Yes	❍ No
Insomnia	❍ Yes	❍ No

Eyes

Double vision	❍ Yes	❍ No
Visual loss	❍ Yes	❍ No

Ear, Nose, Throat and Mouth

Hearing loss	❍ Yes	❍ No
Noise/ringing in ears	❍ Yes	❍ No
Nasal congestion	❍ Yes	❍ No
Sore throat	❍ Yes	❍ No
Trouble swallowing	❍ Yes	❍ No
Hoarseness	❍ Yes	❍ No

Cardiovascular

Chest pain or angina	❍ Yes	❍ No
Heart trouble	❍ Yes	❍ No
Rheumatic fever	❍ Yes	❍ No
Heart murmur	❍ Yes	❍ No
High blood pressure	❍ Yes	❍ No

Neurological

Numbness	❍ Yes	❍ No
Weakness	❍ Yes	❍ No
Stroke	❍ Yes	❍ No
Headache	❍ Yes	❍ No

Allergic/Immunologic

Sneezing	❍ Yes	❍ No
Itchy eyes/nose	❍ Yes	❍ No
Itchy throat	❍ Yes	❍ No
Skin rash	❍ Yes	❍ No
HIV	❍ Yes	❍ No

Respiratory

Asthma	❍ Yes	❍ No
Coughing up blood	❍ Yes	❍ No
TB	❍ Yes	❍ No
Pneumonia	❍ Yes	❍ No
Snoring	❍ Yes	❍ No
Trouble breathing at night	❍ Yes	❍ No

Gastrointestinal

Indigestion/heartburn	❍ Yes	❍ No
Ulcer	❍ Yes	❍ No
Hepatitis	❍ Yes	❍ No
Jaundice (yellowing)	❍ Yes	❍ No
Blood in stool	❍ Yes	❍ No
Black, tarry stools	❍ Yes	❍ No

Genitourinary

Bladder trouble	❍ Yes	❍ No
Prostate disease	❍ Yes	❍ No
Kidney disease	❍ Yes	❍ No

Musculoskeletal

Arthritis	❍ Yes	❍ No

Endocrine

Diabetes	❍ Yes	❍ No
Thyroid disease	❍ Yes	❍ No

Hematologic

Bleeding disorder	❍ Yes	❍ No
Easy bleeding	❍ Yes	❍ No

Psychiatric

Depression	❍ Yes	❍ No
Anxiety	❍ Yes	❍ No

The above information is accurate to the best of my knowledge.

_____
Patient Name

_____
Patient Name or Guardian Signature

_____
Date

I have reviewed the above information with the patient.

_____
Physician Signature

_____
Date