New Patient History Form **Hill Country Ear, Nose & Throat, P.A.**

Updated 05/15/13

Full Name:	DOB:	Age:
Primary Doctor (if any)?	Referring Doctor (if any)?	
Pharmacy:	Pharmacy Address:	Pharmacy Phone #:

CHIEF COMPLAINT

Describe the problem that you are being seen for today:

How long have you had these symptoms?

ENT COMPLAINTS (Current)

Ears	**Nose**	**Sinuses**	**Throat**	**Larynx**
☐ Dizziness	☐ Bleeding	☐ Facial Pain	☐ Difficulty Swallowing	☐ Cough
☐ Drainage	☐ Drainage	☐ Headache	☐ Pain	☐ Dryness
☐ Ear Pain	☐ Dryness	☐ Infections	☐ Painful Swallowing	☐ Hoarseness
☐ Fullness	☐ Nasal Obstruction	☐ Sinus Pressure	☐ Snoring	☐ Noisy Breathing
☐ Hearing Aids	☐ Post-Nasal Drainage		☐ Tonsillitis	☐ Reflux
☐ Hearing Loss	☐ Trauma			☐ Voice Changes
☐ Infections				
☐ Ringing				

PAST HISTORY

Disease Name:	Date Onset	Disease Name:	Date Onset
☐ AIDS		☐ Hepatitis B	
☐ Alcoholism		☐ Hepatitis C	
☐ Allergic Rhinitis		☐ High Blood Pressure	
☐ Anemia		☐ HIV	
☐ Asthma		☐ Hyperthyroidism	
☐ Bladder Cancer		☐ Hypothyroidism	
☐ Bronchitis		☐ Kidney Disease	
☐ Coagulation Defect		☐ Liver Disease	
☐ Congestive Heart Failure		☐ Neck: Malignant, Thyroid Mass	
☐ COPD		☐ Nose: Nasal Fracture, Closed	
☐ Diabetes, Type 1		☐ Pneumonia	
☐ Diabetes, Type 2		☐ Rheumatic Fever	
☐ Drug dependence		☐ Seizure	
☐ Enlarge Prostate		☐ Sleep Apnea	
☐ Fatigue		☐ Stroke	
☐ Heart Attack		☐ Thyroid Gland Neoplasm Benign	
☐ Heart Murmur		☐ Tuberculosis	
☐ Hepatitis A		☐ Urinary Tract Infection	

SURGICAL HISTORY (Please list all surgeries - Especially ENT surgeries like tonsillectomy, nasal surgery, etc.)

Operation	Year	Operation	Year

PLEASE TURN OVER

MEDICATIONS (Please list all medications including aspirin, advil, blood thinners, birth control pill, etc. - Attach if needed)

Medication	Dose	Frequency	Medication	Dose	Frequency

Do you take any herbal medications or supplements?
☐ No ☐ Yes Please List:

Drug Allergies (reaction):
☐ NKDA (No Known Drug Allergies)

FAMILY HISTORY Check (✔) if your blood relatives have had any of the following.

Disease	Relationship to you	Disease	Relationship to you
☐ Allergy		☐ Heart Disease	
☐ Anesthesia problems		☐ Thyroid Cancer	
☐ Bleeding Tendency		☐ Other	

REPRODUCTIVE HISTORY

Females: Are you pregnant? ☐ No ☐ Yes ☐ Maybe If Yes / Maybe date of last Menstrual Period:

Total number of pregnancies: Date of Last Menstrual Period:

SOCIAL HISTORY

Marital Status (mark one) ☐ Single ☐ Married ☐ Widowed

Do you / did you smoke?
☐ No ☐ Yes Packs each day? For how many years? When did you stop?

Do you / did you use oral tobacco?
☐ No ☐ Yes Times each day? For how many years? When did you stop?

Do you / did you ever drink alcohol?
☐ No ☐ Yes Drinks each day? For how many years? When did you stop?

Do you / did you drink coffee / caffeinated drinks?
☐ No ☐ Yes Cups each day? For how many years? When did you stop?

Occupation (If retired, please list previous occupations and current activities): Date stopped working:

REVIEW OF SYSTEMS

Constitutional	**Cardiovascular**	**Integument**	**Endocrine**
☐ Fever	☐ Chest Pain	☐ Rash	☐ Heat Intolerance
☐ Chills	☐ Heart Rhythm Problems	**Neurologic**	☐ Cold Intolerance
☐ Night Sweats	**Respiratory**	☐ Weakness	**Psychiatric**
☐ Weight Loss	☐ Shortness of Breath	☐ Numbness	☐ Depression
☐ Weight Gain	☐ Coughing Up Blood	☐ Speech Difficulties	☐ Anxiety
☐ Fatigue	☐ Cough	☐ Loss of Balance	**Hemat/Lymph**
Eyes	**Gastrointestinal**	**Musculoskeletal**	☐ Easy Bleeding
☐ Blurred Vision	☐ Difficulty Swallowing	☐ Limited Range of Motion in the Neck	☐ Easy Bruising
☐ Double Vision	☐ Reflux		☐ Bleeding after Surgery
☐ Burning	**Genitourinary**	☐ Back Pain	**Allergic-Immunologic**
☐ Drainage	☐ Difficulty Voiding		☐ Allergic Dermatitis / Exzema
☐ Itching			☐ Rash
☐ Dry Eyes			

SIGNATURE of person completing the form: **DATE:**