Lakeshore
EAR, NOSE, THROAT CENTER, PC

ADULT HEALTH HISTORY

Today's Date: _____/_____/_____

Patient's Name: _____ Date of Birth: _____/_____/_____

Patient's Height: _____ Patient's Weight: _____

Preferred Phone Number: (_____)_____ Email: _____

Primary Care Physician: _____

Did a physician refer you to Lakeshore ENT? ☐Yes ☐ No If "Yes," which physician: _____

Where does your physician send you for testing? _____

How did you hear about us if you were not referred by a physician? ☐ Family ☐ Friend ☐ Internet ☐Other

Preferred Pharmacy (name and phone number): _____

REASON FOR VISIT: *(please answer all questions that apply)*

What is the reason for today's visit? _____

When did this problem/pain start? _____

Where is problem/pain located? _____

What makes problem/pain worse? _____

What makes problem/pain better? _____

What is severity of problem/pain? (*circle one*) 0 (none) 1 2 3 4 (moderate) 5 6 7 8 9 10 (severe)

What medications/treatments have you tried for this problem? _____

_____

MAJOR SURGERIES:

What	Where (what facility?)	When
1.		
2.		
3.		
4.		

MEDICATIONS:

Do you use any of the following? ☐ Aspirin ☐ Motrin/Ibuprofen ☐ Plavix ☐ Coumadin ☐ Vitamin E

Medication list attached: ☐Yes ☐ No If "No," list all current medications below, including dose and frequency:

_____

_____

_____

List medication allergies and reactions: _____

_____

MEDICAL HISTORY: *(please check all that apply)*

☐Allergic Rhinitis	☐Cancer (what area of body?		☐Migraines
☐Anesthesia Problems	☐COPD (lung disease)	☐Hepatitis	☐Reflux (GERD)
☐Asthma	☐Diabetes	☐High Blood Pressure	☐Stroke
☐Anxiety	☐Heart Disease	☐Kidney Disease	☐Thyroid Disease
☐Autoimmune Disorder	☐Other (please specify):		
☐Blood Clots			

(PLEASE COMPLETE THE NEXT PAGE OF THIS FORM)

Patient's Name: _____

Date of Birth: _____/_____/_____

FAMILY MEDICAL HISTORY: *(please check all that apply and note relationship)*

☐Asthma	☐Cancer	☐Heart Disease
☐Bleeding Disorders	☐Hearing Loss	☐High Blood Pressure

SOCIAL HISTORY:

Smoking/tobacco products (cigarettes, cigars, chewing tobacco): ☐Yes ☐No Number of years: Number of packs/day: When did you quit?
What is your occupation? Are you retired? ☐Yes ☐No
Alcohol: ☐Yes ☐No Daily amount: How long? When did you quit?
Do you use recreational/illicit drugs? ☐Yes ☐No If yes, what drugs?
Are you hard of hearing or deaf in one or both ears? ☐Yes ☐No
Do you have special religious, spiritual, or cultural needs that we should to be aware of? ☐Yes ☐No If yes, please explain:

REVIEW OF SYSTEMS: *(please check all that apply)*

Constitutional: ☐fatigue ☐fever ☐weight loss (_____lbs) ☐weight gain (_____lbs)
Eyes: ☐blurred vision ☐double vision ☐itching ☐burning ☐eye pain
Ears: ☐difficulty hearing ☐ear pain ☐vertigo ☐tinnitus (ringing) ☐ears feel pressured ☐discharge from ears
Nose: ☐frequent nosebleeds ☐nasal congestion ☐nose/sinus problems ☐rhinorrhea (nasal mucus) ☐sinus pressure ☐blockage/obstruction
Mouth/Throat: ☐sore throat ☐bleeding gums ☐snoring ☐dry mouth ☐oral abnormalities ☐mouth ulcer ☐teeth abnormalities ☐difficulty swallowing ☐post nasal drip ☐hoarseness ☐mouth breathing
Neurologic: ☐fainting ☐frequent headaches ☐seizures ☐numbness ☐weakness ☐migraines ☐restless legs
Cardiovascular: ☐chest pain ☐history of heart murmur ☐dyspnea on exertion ☐palpitations ☐edema ☐light-headed on standing
Respiratory: ☐wheezing ☐shortness of breath ☐hemoptysis ☐sputum production ☐sleep apnea ☐cough
Genitourinary: ☐difficulty urinating ☐pain during urination ☐urinary retention
Gastrointestinal: ☐vomiting ☐heartburn ☐painful swallowing ☐no appetite ☐increased appetite
Hematologic/Lymphatic: ☐swollen glands ☐easy bruising ☐excessive bleeding
Psychiatric: ☐depression ☐anxiety ☐restless sleep
Musculoskeletal: ☐muscle aches ☐joint pain/arthralgia
Skin: ☐rash ☐itching ☐dry skin ☐growths/lesions
Endocrine: ☐increased thirst ☐increased drinking ☐increased hunger
Allergy/Immunologic: ☐frequent sneezing ☐runny nose

Please list any other problems or concerns you think the physician should be aware of: _____

_____

_____

Patient/Guardian Signature: _____