Currens Lane Melvin Moore
Rheney Roberts Seal Audio

Asheville Ear, Nose & Throat
MEDICAL HISTORY

ID #: _____
(For Office Use Only)

Date: _____ Home Phone: ( ) -

Patient Name: _____ Age: _____ Birthdate: / /

Referring Physician:
(First and Last Name) _____

Family Physician:
(First and Last Name) _____

Brief reason for today's visit: _____

Questions Regarding Patient (Circle One)

Smoke YES NO Packs per day _____
Previous Smoker YES NO
- Number of years _____ Stopped for _____ years
- If patient is child, does anyone in the household smoke? YES NO
Chew/Dip YES NO
Alcohol YES NO Drinks per day _____
Pregnant YES NO
Children YES NO How Many? _____
Married Single Divorced Widowed
-If patient is child, do they live with parent or other? _____
Recreational drugs YES NO

List Past Surgeries: *(name and year of surgery)*

_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Medical History: *Please complete the questionnaire to the best of your memory. If there is a question about an item, please ask for assistance.* ***Circle yes or no for each item.*** *Thank you.*

Cardiovascular

YES NO Heart attack
YES NO Heart failure
YES NO High blood pressure
YES NO Circulation problems
YES NO High Cholesterol
YES NO Pacemaker

Endocrine

YES NO Diabetes
YES NO Thyroid disease

Do you have or have you been treated for (NOT including immunizations):

YES NO Hepatitis A, B, C
YES NO TB (tuberculosis)
YES NO HIV/AIDS
YES NO CMV virus
YES NO MRSA

Other Medical Problems:

_____
_____
_____

Pulmonary

YES NO Asthma
YES NO Emphysema
YES NO Sleep apnea
YES NO C pap machine
YES NO Pulmonary embolus

Skin

YES NO Eczema
YES NO History of skin cancer

Intestinal

YES NO Stomach / ulcers
YES NO Jaundice
YES NO GERD

Child Immunology

YES NO Current Immunizations

Urinary

YES NO Kidney stones
YES NO Prostate problems

Orthopedic

YES NO Arthritis

Neurologic

YES NO Stroke / CVA
YES NO Seizures
YES NO Glaucoma

Hematology / Lymphatic

YES NO History of blood clots or DVT
YES NO Lymphoma
YES NO Bleeding disorder

Cancer

YES NO Thyroid cancer
YES NO Head & neck cancer
YES NO Other:

Family History: *Please specify which member of your family have had the following medical problems (only needed for mother, father, sister, brother).*

YES NO Cancer (what kind) _____
YES NO High blood pressure _____
YES NO Heart attack _____
YES NO Bleeding problems

YES NO Reactions to Anesthesia _____
YES NO Diabetes _____
YES NO Hearing loss _____
YES NO Other diseases

Form completed by: _____ Signature: _____

→ → → → OVER → → → →

List Medications: *(include those you buy without a prescription, include vitamins & natural products):*

Medications Patient is Allergic to: *(list reactions)*

PHARMACY INFORMATION *Please provide at least the name and approximate location for prescription purposes.*

Name: _____ Phone Number: ( ) -

Address: _____ City: _____ State: ____

Current Symptoms: *Please complete the questionnaire to the best of your memory. If there is a question about an item, please ask for assistance.* ***Circle yes or no for each item.*** *Thank you.*

Ear			**Nose**		
YES	NO	Hearing loss	YES	NO	Nasal Obstruction
YES	NO	Ringing in the ears	YES	NO	Purulent Nasal
YES	NO	Ear pain			Drainage
			Other		
Throat			YES	NO	Dizziness
YES	NO	Difficulty swallowing	YES	NO	Face Pain
YES	NO	Hoarseness	YES	NO	Neck Mass
YES	NO	Sore throat	YES	NO	Shortness of breath