SUBURBAN EAR, NOSE & THROAT ASSOCIATES, LTD. – Confidential Health History

Name______________________________ Age___________ Date_______________
Where you referred by another physician? NO YES, If yes, who?__________________________________

LIST OF ALL MEDICATIONS (Include over-the-counter and supplements)

_________________________ _______________________ _______________________ __________________________
_________________________ _______________________ _______________________ __________________________

REVIEW OF SYSTEMS: Circle if any of the following are your problems:

Fever	Heartburn	Neck lymph node enlargement
Significant weight change	Hair loss	Neck lymph node tenderness
Double vision	Headache	Prior blood transfusion
Ear pain	Muscle tone problems	Weakened immune system
Irregular heart beat	Lump in thyroid	Frequent infections
Shortness of breath	Chemical dependency	Seasonal allergy symptoms
Cough	Excessive bleeding/bruising	Year-round allergy symptoms

PAST MEDICAL HISTORY: Circle if any of the following are your problems:

AIDS	Hay fever	Lymphoma
Alcoholism	Headache	Migraines
Allergies, environmental	Hepatitis	Mitral valve prolapse
Anxiety/Depression	HIV infection	Heart attack/MI
Asthma	High blood pressure	Sleep apnea
Cancer______________________	HPV infection	Psychiatric illness
Coronary artery disease	Hypotonia/low muscle tone	Speech problems
Diabetes, type I	Irregular heart beat/arrhythmia	Language delay
Diabetes, type II	Kidney dialysis	Stroke/CVA
Emphysema/COPD	Kidney disease	Thyroid nodule
Gastroesophageal reflux (GERD)	Leukemia	Transient ischemic attack/TIA Tuberculosis
Glaucoma	Liver disease	Ulcer (stomach)

Any other medical conditions we should be aware of? ____

PAST SURGICAL HISTORY: Circle if you have had any of the following surgeries:

Adenoidectomy	Heart surgery	Salivary gland removal
Any implants (other than dental)?	Mastoid surgery	Septoplasty
Where?___________________	Neck dissection	Sinus surgery
Cardiac stents	Pacemaker	Thyroidectomy
Carotid artery surgery	Parathyroidectomy	Tonsillectomy
Ear tubes	Radiation for cancer	Wisdom tooth removal
Eardrum repair	Rhinoplasty/'nose job'	

Any other surgeries we should be aware of? ____

ALLERGIES: Any known drug allergies? Circle YES or NO
If yes, please circle if you are allergic to the following: IV contrast dye Latex
Any other allergies? If yes, please list: ________________ _______________ _______________ _______________

FAMILY HISTORY: Circle if any of your immediate family members have the following conditions:

Adopted	Bleeding problems	Thyroid disease
Family history unknown	Bruising problems	Weakened immune system
Asthma	Hearing loss	
Autoimmune disease	Problems with anesthesia	

SOCIAL HISTORY: Please circle your answer to the following questions:
Is the patient in daycare? NO YES
Has/does the patient use tobacco? NO YES, If YES on average, ____pack/day, ____years, OR quit in______
Does the patient use alcohol? NO YES, If YES on average, _____drinks/day, ____years, OR quit in ______

I certify the above Confidential Health History is correct to the best of my knowledge. I will not hold my doctor or his/her associates responsible for any errors or omissions that I have made in completion of this form. I will inform my doctor of any changes that occur.

Patient/Parent Signature	Date	Reviewed by (Physician)	Date	Entered by	Date