COMMUNITY EAR, NOSE, THROAT AND ALLERGY
NEW PATIENT HISTORY FORM

Name: _____ Date of Birth: _____ Age: ___

Referring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

Weight: _____ Temp:_____

Reason for visit: _____
_____
_____
_____

Is the reason for your visit related to an accident or injury?_____ If yes, when?_____
Please indicate where accident happened at (circle one)? Work Auto Other_____

Medication Allergies: _____
Food Allergies: _____
Other Allergies: _____
Latex allergy: Yes No

Immunization Status: Up to Date ___ Not Sure ___ Explain _____

Family History: (M = Mother, F = Father, B = Brother, S = Sister, C = Child, etc.)

Hearing loss	___	Asthma	___	Heart Disease	___
Ear surgery	___	Allergies	___	Neurologic	___
Vertigo	___	Diabetes	___	Bleeding Problems	___
Cancer	___	Hypertension	___	Sickle Cell Anemia	___
Bronchitis	___	Autoimmune	___	Lupus	___
Thyroid disease	___				

Elaborated on any of the above as necessary:_____
_____
_____

Past Medical History: (C = Current problem, P = Past problem, I = Intermittent problem)

Ear infections	___	Dizziness	___	Difficulty Breathing	___
Sinus infections	___	Vertigo	___	Difficulty Swallowing	___
Nasal allergies	___	Ear Noises	___	Swollen Glands	___
Asthma	___	Hearing Loss	___	Acid Reflux	___
Headaches	___	Post Nasal Drip	___	Positive HIV test	___
Exposure to HIV	___	Nosebleeds	___	Dry Mouth	___
Cough	___	Hypertension	___	Diabetic	___
Thyroid problems	___	Heart trouble	___	Lung disease	___
Stroke	___	Anemia	___	Convulsive disorder	___
Hepatitis	___	Tuberculosis	___	Kidney disease	___

Surgical History: (Relating to this visit and / or any other surgeries)

_____
_____
_____
_____
_____
_____
_____

********** Please turn over – complete 2nd page of form **********

Patient Name: _____ **DOB:** _____

Diagnostic Testing: **(where and when)**

Allergy testing / results: _____
Hearing or balance testing: _____
CT scans or MRI scans: _____
X-rays: _____
Sleep Study: _____
Thyroid Testing: _____
Swallowing Test: _____
Other: _____

Social / Travel History

Tobacco Use: Current ___ Past ___ ___ packs per day x ___ yrs Quit _____
Alcohol Use: Never ___ Rarely ___ Social ___ Weekly ___ Daily ___
Caffeine Use: Coffee ___ oz per day Soda ___ oz per day Tea ___ oz per day
Drug Use: Any history or treatment for substance abuse _____
Occupation: _____
Noise exposure: _____
Sports: _____
Daycare / Preschool: ___ days a week
Private Babysitter: ___ days a week
Tobacco exposure: _____
Pets at home: _____

Medications: **(R = daily, O = as needed, V = vitamins or supplements)**

_____
_____
_____
_____
_____
_____
_____

Pregnancy Status: May be pregnant ___ Pregnant ___ Not Pregnant ___

Patient Systems Review: (symptoms you are currently having – current problems)

Weight loss / gain	_____	Hoarseness	_____
Fatigue	_____	Mouth ulcers	_____
Fever	_____	Voice changes	_____
Night sweats	_____	Neck Mass	_____
Change in wart	_____	Neck Pain	_____
Change in mole	_____	Swollen Glands	_____
Hives / rash	_____	Cough	_____
Blurred vision	_____	Snoring	_____
Double vision	_____	Difficulty Breathing	_____
Hearing loss	_____	Difficulty breathing on exertion	_____
Ear Pain	_____	Fainting / Blackout	_____
Ear Ringing	_____	Difficulty Swallowing	_____
Spinning Sensation	_____	Heartburn	_____
Nasal Congestion	_____	Indigestion	_____
Sinus Pain	_____	Joint Pain	_____
Nasal Drainage	_____	Memory loss	_____
Headache	_____	Sore throat	_____