Patient History Form

Patient Name: _____ **Primary Care Physician:** _____

What is the reason for your visit today? _____

_____

Medical History

List your present medications (include over the counter, vitamins and herbal supplements).

Medication	Dosage/Frequency	Medication	Dosage/Frequency

Are you on blood thinner, ibuprofen, or a daily aspirin? Yes _____ No _____

List all past/present medical illnesses

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

List previous surgeries/hospitalizations

Surgery/Hospitalization	Approximate Date	Surgery/Hospitalization	Approximate Date

List all allergies to medications Any allergy to Lidocaine or latex? Yes _____ No _____

Do You?

Yes _____ No _____ Smoke? If yes, how many packs per day? _____

Yes _____ No _____ Drink? If yes, circle one: Wine Beer Whiskey

Yes _____ No _____ Chew?

Yes _____ No _____ Are you a previous smoker? If yes, when did you quit?_____

Yes _____ No _____ Do you have a history of alcohol or substance abuse?

Family History	No History	Un Known	Mother	Father	Grand Mother	Grand Father	Siblings	Aunts or Uncles
Diabetes								
Cancer								
Heart Disease								
High Blood Pressure								
Asthma								
History of Bleeding								
Hearing problems								
Allergy/Sinus Problems								
Other:								
Other:								
Other:								
Other:								

Review of Systems

Last Name: _____ **First Name:** _____ **Middle:** _____

Social Security #: _____ **Date of Birth:** ____ / ____ / ____ **Today's Date:** ____ / ____ / ____

Do you have any problems related to the following? Please circle Yes or No

Ear:
Decreased Hearing Y N
Pain Y N
Fullness Y N
Infection Y N
Ringing Y N
Dizziness Y N
Hearing Aids Y N
Drainage/Bleeding Y N
Other _____ Y N

Nose:
Blockage/Breathing Y N
Congestion Y N
Drainage Y N
Infection Y N
Trauma Y N
Sneezing Y N
Bleeding Y N
Loss of Smell Y N
Other _____ Y N

Throat:
Lumps/Growth Y N
Pain Y N
Swelling Y N
Dryness/Itching Y N
Tonsillitis Y N
Hoarseness Y N
Voice Change/Loss Y N
Frequent Clearing Y N
Cough Y N
Other _____ Y N

Sinus:
Eye/Facial Swelling Y N
Change in Vision Y N
Pain/Pressure Y N
Drainage Y N
Headaches Y N
Infection Y N
Congestion Y N
Polyps Y N
Other _____ Y N

Mouth:
Sores on Tongue Y N
Gum Swelling Y N
Lumps/Growth Y N
Bleeding Y N
Loss of Taste Y N
Pain Y N
Bad Breath Y N
Other _____ Y N

Eyes:
Watery Y N
Drainage Y N
Itching Y N
Change in Vision Y N
Redness Y N

Neurological:
Tremors/Seizures Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Headache Y N
Other _____ Y N

Endocrine:
Diabetes Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Hair Loss Y N
Weight Loss Y N
Weight Gain Y N
Muscle Pain Y N
Fatigue Y N
Constipation Y N
Other _____ Y N

Gastrointestinal:
Abdominal Pain Y N
Nausea/Vomiting Y N
Indigestion/Heartburn Y N
Night Time Cough Y N
Trouble Swallowing Y N
Other _____ Y N

Skin:
Skin Rash Y N
Hives Y N
Persistent Itch Y N
Other _____ Y N

Musculoskeletal:
Joint Pain Y N
Neck Pain/Back Pain Y N
Muscle Weakness Y N
Other _____ Y N

Respiratory:
Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other _____ Y N

Hematological/Lymphatic:
Swollen Glands Y N
Blood Clotting Problems Y N
Other _____ Y N

Psychological/Emotional:
Depression Y N
Anxiety Y N
Medication Y N
Other _____ Y N

Allergic/Immunological:
Hay Fever Y N
Drug Allergies Y N
Food Allergies Y N
Other _____ Y N

General:
Frequently Tired Y N
Night Sweats Y N
AIDS Y N
Hepatitis Y N
Other _____ Y N

Cardiovascular:
Chest Pain Y N
High Blood Pressure Y N
Irregular Heart Rate Y N
Other _____ Y N

CONSENT FOR TREATMENT OF A MINOR

A minor is anyone 17 years of age or younger.

Patient Name_____ Patient DOB_____

Thank your for entrusting the care of your child to Central Missouri Ear, Nose, Throat, Sinus & Allergy. To provide the best quality of care for your child we require that a parent or legal guardian accompany the child to appointments. We realize that your child may need to be seen for an acute sick visit and a parent or legal guardian may be unable to be present. By completing the information below we will be able to meet the needs of your child during your absence.

In the absence of a parent or legal guardian, I give the person(s) listed below permission to seek medical care and treatment for my child. I also realize that the person below may have access to pertinent protected health information if medically necessary. These individuals will be asked to present identification at the time of the visit. If someone other than these persons listed below brings in your child, we will attempt to contact a parent or legal guardian for verbal permission to treat.

	NAME	RELATIONSHIP	PHONE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Please be sure the person accompanying your child has all the pertinent information regarding your child's illness in order to provide the highest quality of care.

_____ _____ _____

Signature Relationship Date

Parent(s) or Legal Guardian(s) contact information:

Name: _____
Relationship:_____
Home Number: _____
Cell Number: _____
Work Number: _____

Name: _____
Relationship:_____
Home Number: _____
Cell Number: _____
Work Number: _____