



# Oregon Ear, Nose, and Throat Center Patient Health History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Gender  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_  
Referring Provider \_\_\_\_\_  
Reason for today's visit \_\_\_\_\_

How did you hear about us?  Provider referral  Phone book  Newspaper  Web page  Word of mouth  Other \_\_\_\_\_

Allergies to medication (list medications) \_\_\_\_\_  
Are you latex sensitive?  No  Yes Do you have a bleeding disorder?  No  Yes

Current Medications (list name, dosage, and frequency) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous surgeries	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any problems with anesthesia?  No  Yes If yes, please explain \_\_\_\_\_

Chronic Medical Problems (diseases, problems requiring medication, health issues for which your provider treats you):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family Member	Alive	Deceased	Age	Health problems or cause of death
Grandmother (mother's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandfather (mother's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandmother (father's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandfather (father's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Social History  
Occupation \_\_\_\_\_  
Marital Status  Single  Married  Divorced  Widowed  Domestic partner  
Do you have children?  No  Yes If yes, how many? \_\_\_\_\_  
Do you live alone?  No  Yes If no, who lives with you? \_\_\_\_\_  
Do you smoke?  No, never have  
 No, quit \_\_\_\_\_ years ago. I smoked \_\_\_\_\_ packs/day for \_\_\_\_\_ years.  
 Yes, I smoke cigars, pipe, or other products. Estimate quantity \_\_\_\_\_  
 Yes, I smoke \_\_\_\_\_ packs of cigarettes/day for \_\_\_\_\_ years.  
 I use or have used smokeless tobacco. Estimate quantity \_\_\_\_\_  
Do you drink alcohol?  No, never  No, but I used to  Yes, daily  Yes, 1+/week  Yes, 1+/month



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### Constitutional

- No  Yes Fever
- No  Yes Weight loss
- No  Yes Night sweats

### Ear, Nose, Throat

- No  Yes Hearing loss  Left  Right  Both
- No  Yes Hearing aids  Left  Right  Both
- No  Yes Ear pain  Left  Right  Both
- No  Yes Ear drainage  Left  Right  Both
- No  Yes Ear infections  Left  Right  Both
- No  Yes Ringing ears  Left  Right  Both
- No  Yes Balance trouble (vertigo, spinning)
- No  Yes Nosebleeds  Left  Right  Both
- No  Yes Snoring or Sleep Apnea
- No  Yes Sinus infections
- No  Yes Nasal congestion
- No  Yes Nasal drainage: Color \_\_\_\_\_
- No  Yes Loss of smell
- No  Yes Headaches
- No  Yes Dental problems or pain
- No  Yes Mouth sores
- No  Yes Sore throat
- No  Yes Hoarseness or change in voice
- No  Yes Difficulty swallowing

### Allergy & Immunology

- No  Yes Inhalant (nasal) allergies
- No  Yes Food allergies
- No  Yes Immunologic disorders
- No  Yes HIV/AIDS

### Eyes

- No  Yes Wear glasses/contacts: Last exam \_\_\_\_\_
- No  Yes Loss of vision, double vision, blurred vision?
- No  Yes Infection
- No  Yes Injuries
- No  Yes Glaucoma or cataract

### Cardiovascular

- No  Yes High blood pressure
- No  Yes Coronary artery disease or Heart Attack
- No  Yes Chest pain or Angina: Date of last EKG \_\_\_\_\_
- No  Yes Irregular rhythm or pulse
- No  Yes Heart murmur
- No  Yes Congestive heart failure or Swollen Ankles

### Hematologic/Lymphatic

- No  Yes Cancer: Type & treatment \_\_\_\_\_
- No  Yes Anemia
- No  Yes Easy bleeding or bruising
- No  Yes Persistent swollen glands or lymph nodes
- No  Yes Blood transfusion: Date \_\_\_\_\_

### Respiratory

- No  Yes Asthma
- No  Yes Chronic cough
- No  Yes Emphysema or COPD
- No  Yes Shortness of breath
- No  Yes Pneumonia or bronchitis
- No  Yes Lung cancer
- No  Yes Bloody sputum
- No  Yes Tuberculosis
- No  Yes Date of last chest x-ray: \_\_\_\_\_

### Gastrointestinal

- No  Yes Reflux or Heartburn
- No  Yes Ulcers or Gastritis
- No  Yes Liver disease
- No  Yes Hepatitis  B  C
- No  Yes Nausea or Vomiting
- No  Yes Blood in vomit
- No  Yes Abdominal pain

### Genitourinary

- No  Yes Renal failure
- No  Yes Prostate enlargement or cancer
- No  Yes Pain or blood with urination
- No  Yes Difficulty starting/stopping stream
- No  Yes Urinary tract infections
- No  Yes Pregnant

### Musculoskeletal

- No  Yes Arthritis
- No  Yes Broken bones \_\_\_\_\_
- No  Yes Weakness
- No  Yes Pain:  Arm  Leg  Back
- No  Yes Joint pain or swelling

### Metabolic

- No  Yes Diabetes
- No  Yes Thyroid problems
- No  Yes Hormone problems

### Neurologic

- No  Yes Stroke
- No  Yes Seizures
- No  Yes Fainting spells (blacking out)
- No  Yes Weakness or discoordination  Face  Arm  Leg
- No  Yes Speech difficulty

### Skin

- No  Yes Skin disease: \_\_\_\_\_
- No  Yes Skin cancer: Type & location \_\_\_\_\_

### Psychiatric

- No  Yes Anxiety
- No  Yes Depression
- No  Yes Other disorder/treatment \_\_\_\_\_

The above information is accurate to the best of my knowledge. \_\_\_\_\_

Patient Signature

Date

I have reviewed the above information with the patient.

Physician Signature

Date

Physician Name (Printed)