

# St. Joseph's Ear, Nose & Throat Clinic

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What are we seeing you for today? \_\_\_\_\_

Family physician: \_\_\_\_\_ Referring physician: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Current medications including dosage: \_\_\_\_\_

Are you now taking?  Aspirin  Anti-Inflammatory  Coumadin  Vitamin E

Allergies to medications including reactions: \_\_\_\_\_

**Adult Social History** (Complete section for adults only)

Marital Status: S M D W Occupation: \_\_\_\_\_

**Smoking History:**

Never Smoked  
 Currently Smokes \_\_\_\_\_ years \_\_\_\_\_ pack/day  
 Previously Smoked How long ago \_\_\_\_\_ # of years smoked \_\_\_\_\_

Alcohol Use:  Yes  No Drinks/day \_\_\_\_\_

Recreational Drug Use:  Yes  No Type: \_\_\_\_\_

Is there any chance that you could be pregnant?  Yes  No

**Child Social History** (Complete section for children only)

Is the child in daycare?  Yes  No Days per week: \_\_\_\_\_

Does anyone in the home smoke?  Yes  No Grade in school: \_\_\_\_\_

**Past Medical History**

Have you or any of your family members been treated in the past for the following medical conditions?

	You		Relative(s)			You		Relative(s)	
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anesthetic Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Reflux Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever, Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional family health history: \_\_\_\_\_

**Surgical History**

Past Surgical Procedure(s)  Yes  Never had surgery

Name and date of surgical procedure(s): \_\_\_\_\_

Did you have any surgical complication(s)?  Yes  No Complication(s): \_\_\_\_\_

Any complication(s) with anesthesia?  Yes  No Complication(s): \_\_\_\_\_

**Hospitalization History**

Past Hospitalization(s)  Yes  Never been hospitalized

Reason for hospitalization(s): \_\_\_\_\_

Do you wear hearing aid(s)?  Yes  No Do you wear glasses?  Yes  No

**Current Health**

Do you currently have any of the following medical problems? (Please mark yes or no)

	Yes	No		Yes	No
<b>Heart/Circulation Problems?</b>			<b>Eye?</b>		
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lung/Breathing Problems?</b>		
Pacemaker/defib	<input type="checkbox"/>	<input type="checkbox"/>	Cold/Cough	<input type="checkbox"/>	<input type="checkbox"/>
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
			Snoring	<input type="checkbox"/>	<input type="checkbox"/>
<b>Stomach/Digestive Problems?</b>			TB	<input type="checkbox"/>	<input type="checkbox"/>
Reflux/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<b>Urologic Problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infections	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Dysuria	<input type="checkbox"/>	<input type="checkbox"/>
			Enlarged Prostate	<input type="checkbox"/>	<input type="checkbox"/>
<b>Muscle/Joint Problems?</b>			Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Jaw/TMJ	<input type="checkbox"/>	<input type="checkbox"/>	Excess Urination	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>			
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<b>Glandular Problems?</b>		
Neck/Back	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological Problems?</b>			Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Insulin	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>			
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hematologic/Lymphatic?</b>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
			Aspirin Use	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergic/Immunologic?</b>			AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Hives and/or Rash	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Angioedema	<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulants Use	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendencies	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Anti-Inflammatory Use	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>			

<b>Psychiatric?</b>			<b>Cancer?</b>		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Prostate	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Recent Life Crisis	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
			Breast	<input type="checkbox"/>	<input type="checkbox"/>
			Lung	<input type="checkbox"/>	<input type="checkbox"/>
			Colon	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
			Oral/Throat	<input type="checkbox"/>	<input type="checkbox"/>

Additional medical information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_