

Suburban Ear, Nose and Throat Associates, Ltd.
CONFIDENTIAL HEALTH HISTORY

Name _____ Age _____ Date _____

Were you referred to us by another physician? YES NO

If yes, who? _____ Phone (____) _____

If no, how did you find our office? _____

LIST ALL MEDICATIONS (Include over-the-counter)

ANY Allergies? Yes No
If yes, list ALL

YOUR PAST MEDICAL / SURGICAL HISTORY

Has the patient ever had any surgery and/or been hospitalized? NO YES If yes, please fill in below.

Year	Institution	Reason/Outcome

ANY other medical illnesses and/or problems that we should know about? YES NO If yes, please fill in below.

Year	Illness/Problem	Outcome

Grade in School? ____ N/A - In Daycare? N/A Yes No - Is the patient pregnant? N/A Yes No
HEALTH HABITS – **CIRCLE** if have/had used: Tobacco Alcohol Recreational Drugs

SYSTEM REVIEW - Any problems with any of the following? Circle "NO" if none, otherwise, please **CIRCLE** those that apply.

GENERAL:	NO	Significant weight change	Fever	
HEME/ONC:	NO	Bleeding or Bruising problem	Prior Blood Transfusion	Leukemia/Lymphoma
	NO	Any known cancer not otherwise noted? If so what kind? _____		
ALL/IMM:	NO	Hayfever	Environmental Allergy	Food Allergy Latex Allergy
GI:	NO	Hepatitis	Liver Disease	Ulcers Reflux/Acid Indigestion
INF DZ:	NO	HIV and/or AIDS	Hepatitis	Weakened Immune System
ENDO:	NO	Thyroid Problems	Thyroid Nodule	Diabetes
CV:	NO	High Blood Pressure	Mitral Valve Prolapse	Irregular Heartbeat Pacemaker
	NO	Heart Attack	Heart Disease	Heart Surgery Heart Stents or other vessel Stents
	NO	Ever been told you need antibiotics before any dental procedure? _____		
RESP:	NO	Emphysema	Sleep Apnea	COPD Asthma Tuberculosis
PSYCH:	NO	Chemical Dependency	Alcoholism	Psychiatric Illness
GU:	NO	Kidney Disease	Dialysis	Renal Insufficiency
NEURO:	NO	Headaches	Stroke TIA	Migraines
OPHTH:	NO	Loss of Vision	Double Vision	Glaucoma
ENT:	NO	Speech/Language Delay/Problems	Hypotonia	Muscle Tone Problems Ear Pain
	NO	Prior Head/Neck/Face Trauma or Surgery		
	NO	Prior Ear Surgery		
	NO	Prior Nose/Sinus Surgery		
	NO	Prior Head/Neck/Face Radiation		
	NO	Any Implants Present?		

FAMILY HISTORY - Do any of the patient's blood relatives have/had problems with the following? **CIRCLE** any that apply.

Bleeding or Bruising Problems Problems with Anesthesia Hearing Loss Autoimmune disease Asthma
Thyroid Disease Throat Cancer Weak Immune System Immune Deficiency

I certify the above Confidential Health History is correct to the best of my knowledge. I will not hold my doctor or his 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

Updated Date