TEXAN ENT Specialists

# New Patient Health History Form

Last Name _____ First Name _____ Date of Birth: ____/____/_____

**Pharmacy (Name/Location)**_____

**Reason for today's visit** (please specify how long you have had these symptoms) _____

_____

Have you had any tests, scans (CT or MRI), or treatments for this problem: Yes No

If yes, what was done and which doctor ordered them: _____

## Answer all questions

### 1. MEDICAL HISTORY

Height_____ Weight _____

***DO YOU HAVE OR HAVE YOU EVER HAD (please √ box)***

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Lung Disease (specify _____)
- ☐ Seizures, Epilepsy, Fainting or Dizziness
- ☐ Bleeding Disorder, Anemia, Blood Transfusion or do you bruise easily
- ☐ Liver Disease (Jaundice, Hepatitis)
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Thyroid Disease (_____)
- ☐ Stomach Ulcers or Colitis
- ☐ Any disease, drug, or transplant operation that has depressed your immune system
- ☐ History of Cancer: Type _____ Treatment? _____ When diagnosed? _____
- ☐ Sleep/snoring problems (Please explain:)_____
- ☐ Hearing problems
- ☐ Migraines or other recurrent headaches
- ☐ Do you have any other disease, condition or problem that you think the doctor should know about? _____
- ☐ *No known medical conditions*

**2. FAMILY HISTORY:** List any *Family* illnesses: (heart disease, cancer, etc.) _____

_____

**3. SURGICAL HISTORY:** Please list any surgeries/ hospitalizations you have had (please include date)?

_____

_____

**All responses are kept confidential**

### 4. MEDICATIONS

- ☐ Do you take any aspirins, Ibuprofen, Advil, Motrin, Vitamin E, or blood thinners?
- ♦ Please list all medications you take (include prescription & over-the-counter medications: _____

_____

_____

### 5. ALLERGIES (write 'none' if you have no known allergies)

a. Please list any **drug allergies**_____

_____

b. Please list any seasonal allergies or food allergies: _____

_____

c. Have you been treated for allergies before?
***Y*** ***N*** If yes, When? _____

d. Have you had a severe reaction to allergy treatment or testing? ***Y*** ***N*** If yes, Explain: _____

e. Do you feel worse during certain times of the year?
***Y*** ***N*** What season? ☐*Winter* ☐*Spring* ☐*Summer* ☐*Fall*

f. What precautions do you take for perceived allergy problems? (*pillow covers, air cleaners, etc.*) _____

_____

### 6. SOCIAL HISTORY:

- ☐ Do you smoke or chew Tobacco? How much per day? _____
- ☐ Do you drink Alcohol? How much per day? _____
- ☐ Do you have a Chemical Dependency or Emotional Disorder that may affect the care we provide you?

### 7. FOR WOMEN ONLY

- ☐ Are you pregnant, or is there any chance you might be pregnant?
- ☐ Are you nursing?

**X** _____ _____

**Patient/Guardian Signature** **Print Name** **Date**