Patient Name: _____ **Date:** _____

General Medical History (please check and/or fill in complete information)

1. Brief summary of ENT problems, some of which may not be related to the present complaint:

_____ hearing loss
_____ ear noises
_____ dizziness
_____ facial paralysis
_____ nasal obstruction
_____ nasal deformity
_____ nose bleeds
_____ excess eye skin
_____ mouth sores
_____ jaw joint problem
_____ ear pain
_____ facial pain
_____ eye problem(s)
_____ stiff neck
_____ lump in neck
_____ lump in face or head
_____ trouble swallowing
_____ trouble breathing
_____ other. Please list:

2. Do you have or have you ever had:

_____ diabetes
_____ thyroid disease
_____ kidney disease
_____ other tumor ( )
_____ herpes
_____ hepatitis
_____ cleft palate
_____ severe low blood pressure
_____ lung or breathing problems
_____ irregular heartbeat
_____ rheumatic fever
_____ tuberculosis
_____ multiple sclerosis
_____ Meningitis
_____ diuretics
_____ heart attack
_____ high blood pressure
_____ other heart problems
_____ syphilis
_____ headaches
_____ gonorrhea
_____ arthritis or skeletal problems
_____ intravenous antibiotics
_____ unexplained weight loss
____ other illnesses, please list:
_____ hypoglycemia
_____ angina
_____ stroke
_____ ulcers
_____ glaucoma
_____ cold sores
_____ AIDS/HIV
_____ psych. therapy
_____ cancer of ( )
_____ urinary problems
_____ asthma
_____ blood transfusions

3. Do any blood relatives have:

_____ diabetes _____ cancer _____hypoglycemia _____ heart disease
_____ other major medical problems such as those listed above, please list:

4. Describe serious accidents unless directly related to your doctor's visit here: _____ None
_____ Occurred with head injury, loss or consciousness or whiplash.
_____ Occurred without head injury, loss of consciousness or whiplash.
Please describe:

5. Medication allergies:
_____ None _____ Erythromycin _____ Penicillin _____ Codeine _____ Keflex/Ceclor/Ceftin _____ X-ray dyes
_____ Iodine _____ Sulfa _____ Tetracycline _____ Novocaine _____ Aspirin _____ Adhesive tape
_____ Other, please list:

6. Other allergies, please list: _____ Yes _____ No
Evaluated: (when?) _____
Name and address of allergist:

7. List of all current medications and dosages (include birth control pills and vitamins):

(turn page over)

8. List operations:
_____ Tonsillectomy (age:) _____ Adenoidectomy (age:)
_____ Appendectomy (age:) _____ Heart Surgery (age:)
_____ Other, please list:

9. Smoking history: _____ Yes _____ No _____ Quit
When? _____ Smoke(d) about _____ per day for _____ years.

10. Alcohol: _____Yes _____ No (rarely use) How much per day/week?: _____

11. List toxic drug or chemicals to which you have been exposed:
_____ Lead _____ Mercury _____ streptomycin, neomycin, Kanamycin _____ Other, please list:

12. Have you had X-ray treatment to your head or neck (including treatments for acne, or ear problems as a child), treatments for cancer, etc.? _____ No _____ Yes
Please list:

13. Caffeine consumption: _____ cup(s) or _____ glass(es) per day (coffee, tea, colas, chocolate, etc.)

14. List other drug use: _____ Marijuana _____ Cocaine _____ Other
Please list:

15. What is your occupation?

16. List names of spouse and children:

17. Describe serious health problems of your spouse or children: _____ None _____ Please list:

18. For females: Are you pregnant? _____ Yes _____ No
Are you post-menopausal? _____ Yes _____ No
Have you undergone hysterectomy? _____ Yes _____ No
Were your ovaries removed? _____ Yes _____ No
Are your menstrual cycles regular? _____ Yes _____ No

19. Are you currently contemplating or involved in litigation (legal action) related to your health?