

# Family Ear, Nose & Throat, LLC

## Patient Medical History

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: Male Female Preferred Pronoun: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Pharmacy Preference: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_

List any medications you are currently taking or WE CAN COPY YOUR LIST:

Medication	Dosage	How often taken

Are you ALLERGIC to any medications: Yes No If yes, list below or WE CAN COPY YOUR LIST:

Medication	Type of reaction

Any family history of malignant hyperthermia with anesthesia? YES NO

Have you been hospitalized for non-surgical reasons? YES NO If yes, list hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_

List any surgeries (including childhood- example, tonsils) you have had:

	Year
Ear, Nose & Throat	
Brain	
Heart	
Thyroid/Parathyroid	

Tobacco Use Ever: None Cigarettes Vaping Smokeless Tobacco

Current Smoking Status: Never smoked Former smoker Current every day smoker

Tobacco Use in a Day/# of years: \_\_\_\_\_

Alcoholic Beverages: YES NO If yes, average per day or week: \_\_\_\_\_

Do you use drugs recreationally? YES NO - Marijuana or other \_\_\_\_\_ how often: \_\_\_\_\_

**CIRCLE if you have been diagnosed with any of the following:**

Thyroid Dysfunction

Diabetes

Thyroid Cancer

Blood Clots/DVT

Skin Cancer

High Blood Pressure

Head & Neck Cancer

Heart Disease \_\_\_\_\_

Other Cancer \_\_\_\_\_

Lung Disease \_\_\_\_\_

Migraine Headaches

Autoimmune Disease \_\_\_\_\_

Sleep Apnea

Reflux

Nasal Allergies

**CIRCLE if you have now or have you recently had any of the following:**

No problems now or in the recent past

**Mouth & Throat:**

**General Health:**

bad breath

excessive daytime sleepiness

frequent throat clearing

weight loss

hoarseness

other: \_\_\_\_\_

sensation of something caught in throat

**Eyes:**

snoring

Issue: \_\_\_\_\_

sore throat

**Ears:**

tongue/mouth sores

ringing

other: \_\_\_\_\_

drainage

**Gastrointestinal:**

dizziness

heartburn

hearing loss

trouble swallowing

itchy

pain with swallowing

infection

other: \_\_\_\_\_

pain

**Endocrine:**

other: \_\_\_\_\_

thyroid issues

**Nose & Sinuses:**

parathyroid issues

facial pressure sensation

other: \_\_\_\_\_

nasal obstruction/congestion

**Allergic, Infectious, Immunologic:**

runny nose

Environmental issues: \_\_\_\_\_

sneezing

Infectious Disease: \_\_\_\_\_

other: \_\_\_\_\_

Immune Problems: \_\_\_\_\_