

Upper Cape Ear, Nose & Throat

PERSONAL HEALTH HISTORY

YOUR NAME _____

PRIMARY CARE DOCTOR _____

**PLEASE LIST ALL MEDICATIONS, SPRAYS, DROPS, INHALERS,
SUPPLEMENTS YOU ARE TAKING, PLEASE INCLUDE DOSAGE AMOUNTS**

LIST ANY MEDICATION ALLERGIES _____

LIST ANY OTHER ALLERGIES TO FOOD, LATEX, POLLEN, DUST, ETC

PLEASE LIST ALL YOUR KNOWN MEDICAL DIAGNOSES:

CHILDHOOD _____

ADULTHOOD _____

LIST SURGERIES _____

ANY PROBLEMS WITH ANESTHESIA? _____

RECENT HOSPITALIZATIONS _____

FALLS IN PAST 12 MONTHS? _____ HOW MANY/ _____ IF SO, ANY INJURIES

DISEASES IN RELATIVES:

FATHER _____ **MOTHER** _____

BROTHER _____ **SISTER** _____

GRANDPARENTS _____

IF YOU SMOKE, HOW MANY PACKS PER DAY? _____ SINCE WHEN? _____

OTHER TOBACCO USE _____

IF YOU DRINK ALCOHOL, WHAT DO YOU DRINK, AND HOW MUCH DAILY?

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

Upper Cape Ear, Nose & Throat

PLEASE INDICATE ANY PROBLEMS YOU ARE CURRENTLY EXPERIENCING:

NAME _____ DATE _____

General			Musculoskeletal		
Fever	Y	N	Joint Pain	Y	N
Fatigue	Y	N	Neck Pain	Y	N
Unexplained Weight loss	Y	N	Back Pain	Y	N
Other _____			Other _____		
Eyes			Neurological		
Blurred vision	Y	N	Tremors	Y	N
Double vision	Y	N	Dizzy spells	Y	N
Pain	Y	N	Falls in last 12 months	Y	N
Other _____			How many? _____ Any injury	Y	N
Ears, Nose, and Throat			Psychological		
Pain (where? _____)	Y	N	Depressed	Y	N
Sinus trouble	Y	N	Anxious	Y	N
Trouble swallowing	Y	N	Other _____		
Other _____					
Heart			Hematologic/ Lymphatic		
Chest pain	Y	N	Lymph node pain/ swelling	Y	N
Palpitations	Y	N	Bleeding problem	Y	N
Other _____			Other _____		
Lungs			Endocrine		
Wheezing	Y	N	Heat/cold intolerance	Y	N
Cough	Y	N	Excessive thirst	Y	N
Shortness of breath	Y	N	Tired/ Sluggish	Y	N
Other _____			Other _____		
Gastrointestinal			Skin		
Difficulty swallowing	Y	N	Rash	Y	N
Vomiting blood	Y	N	Itch	Y	N
Bloody or Tarry Stools	Y	N	Skin infection	Y	N
Other _____			Keloid or hypertrophic scar	Y	N
Genitourinary			Allergy/ Immunology		
Discharge	Y	N	Hay fever	Y	N
Pain on Urination	Y	N	Immune deficiency	Y	N
Frequency	Y	N	Arthritis	Y	N
Other _____					

Why are you seeing the doctor today? _____
