Ear, Nose & Throat Specialists, LLC Patient History

Acct #: _____

Name: _____ Date of Birth_____

Briefly describe reason for visit: _____

_____

Symptoms for how long? _____

Prior treatment for this problem: _____

_____

Have you ever been diagnosed or treated with any of the following: (check all that apply)

☐ Nasal Surgery	☐ Asthma	☐ High blood pressure
☐ Sinus Surgery	☐ Diabetes	☐ Heart Attack
☐ Nasal Trauma	☐ Emphysema	☐ Heart valve problem
☐ Ear Surgery	☐ Stomach Ulcers	☐ Stroke
☐ CAT scan sinus or head	☐ _____ other medical conditions	☐ Pacemaker
☐ Cancer of _____	☐ Sleep Apnea	
☐ Chemotherapy	☐ Sleep Study	☐ Liver Disease
☐ Radiation Therapy	☐ Hypothyroid	☐ Anemia
☐ Daily ASPIRIN use	☐ Bleeding or bruising easily	☐ Anesthesia Reaction

Current Medications: (include aspirin, blood thinners, vitamins, herbal, birth control)

_____

_____

Height: _____ **Weight:** _____

List all **ENT Surgeries**: _____

_____

Allergies : (include allergies to medication, contrast or dyes, latex, iodine)

_____

Smoker? **1)** If Yes → Packs per day_____ # of years?_____ **2)** Quit_____ What Year?_____

3) Never smoked ☐ **4)** Snuff or Chewing Tobacco ☐ **5)** Cigar or Pipe ☐

Do you drink beer, wine or liquor on a daily basis? Yes ☐ No ☐

_____ _____

Patient or Guardian Signature Date