Bay Area ENT Specialists
Medical History Form

Patient Name

Have you had any of the following?

Select from below

CONSTITUTIONAL SYSTEMS

Fever	Yes	No
Weight Loss	Yes	No
Loss of Appetite	Yes	No
Fatigue	Yes	No

EAR

Hearing Loss	Yes	No
Ringing	Yes	No
Dizziness	Yes	No
Infections	Yes	No
Discharge	Yes	No

NOSE

Trauma	Yes	No
Obstruction	Yes	No
Snoring	Yes	No
Discharge	Yes	No
Bleeding	Yes	No
Post Nasal Drip	Yes	No

THROAT

Soreness	Yes	No
Difficulty Swallowing	Yes	No
Tonsillitis	Yes	No

Voice Change	Yes	No
Hoarseness	Yes	No

SINUS

Pain	Yes	No
Swelling	Yes	No
Pressure	Yes	No
Frequent Infections	Yes	No

DENTAL

Crowns	Yes	No
Root Canals	Yes	No
TMJ	Yes	No
Trauma	Yes	No

EYES

Blurred Vision	Yes	No
Double Vision	Yes	No
Decreased Vision	Yes	No

RESPIRATORY

Coughing up Blood	Yes	No
Tuberculosis	Yes	No
Shortness of Breath	Yes	No
Wheezing	Yes	No

CARDIOVASCULAR

Chest Pain	Yes	No
Rheumatic Fever	Yes	No
Heart Attack	Yes	No
High Cholesterol	Yes	No

High Blood Pressure	Yes ○	No ○
Leg Edema	Yes ○	No ○
Murmur	Yes ○	No ○
Palpitations	Yes ○	No ○

UROLOGY

Kidney Stones	Yes ○	No ○
Infections	Yes ○	No ○
Tumor	Yes ○	No ○
Bladder Infections	Yes ○	No ○
Urinary Retention	Yes ○	No ○
Incontinence	Yes ○	No ○

ENDOCRINE

Thyroid Problems	Yes ○	No ○
Weight Loss	Yes ○	No ○
Weight Gain	Yes ○	No ○
Diabetes	Yes ○	No ○
Heat/Cold Intolerance	Yes ○	No ○

NEUROLOGIC

Stroke	Yes ○	No ○
Epilepsy	Yes ○	No ○
Seizures	Yes ○	No ○
Migraines	Yes ○	No ○

PSYCHIATRIC

Depression	Yes ○	No ○
Anxiety	Yes ○	No ○
Mental Illness	Yes ○	No ○
Alcoholism	Yes ○	No ○

Drug Dependency y	Yes ◯	No ◯
ADHD	Yes ◯	No ◯

GASTROINTESTINAL

Jaundice	Yes ◯	No ◯
Liver Disease	Yes ◯	No ◯
Abdominal Pain	Yes ◯	No ◯
Constipation	Yes ◯	No ◯
Diarrhea	Yes ◯	No ◯
Reflux	Yes ◯	No ◯
Ulcers	Yes ◯	No ◯

MUSCULOSKELETAL

Arthritis	Yes ◯	No ◯
Back Trouble	Yes ◯	No ◯
Neck Pain	Yes ◯	No ◯

ALLERGY / IMMUNOLOGIC

Asthma	Yes ◯	No ◯
Ha y Fever	Yes ◯	No ◯
Hives	Yes ◯	No ◯
Eczema	Yes ◯	No ◯
Scratch y Throat	Yes ◯	No ◯
AIDS	Yes ◯	No ◯
HIV Positive	Yes ◯	No ◯
Immune Deficiency y	Yes ◯	No ◯

DERMATOLOGY

Rashes	Yes ◯	No ◯
Dr y or Sensitive Skin	Yes ◯	No ◯

Hives	Yes ○	No ○
Skin Cancer	Yes ○	No ○

HEMATOLOGY

Easy Bruising	Yes ○	No ○
Hep C	Yes ○	No ○
Swollen Glands	Yes ○	No ○

SOCIAL HISTORY

Occupation:	Employed ○	Unemployed ○
Alcohol Use:	Yes ○	No ○
Smoking:	Yes ○	No ○
Recreational Drug Use:	Yes ○	No ○
Passive Smoke Exp:	Yes ○	No ○
Caffeine:	Yes ○	No ○
Oral Tobacco:	Yes ○	No ○

FAMILY HISTORY

Has any blood relative ever had?

Hearing Loss	Yes ○	No ○
Thyroid Disease	Yes ○	No ○
Heart Disease	Yes ○	No ○
Diabetes	Yes ○	No ○
Reaction to Anesthesia	Yes ○	No ○
Coronary Artery Disease	Yes ○	No ○
Cancer	Yes ○	No ○
Bleeding Problems	Yes ○	No ○
Hypertension	Yes ○	No ○
Gout	Yes ○	No ○
Stroke	Yes ○	No ○
Lupus	Yes ○	No ○

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