BAY AREA ENT SPECIALISTS MEDICAL HISTORY FORM

Patient name: _____ DOB: _____

Have you had any of the following within the last two weeks?

You may circle Yes ONLY!

CONSTITUTIONAL

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

Have you ever had or do you have any of these problems?

ENT

Hearing loss	Yes	No
Dizziness	Yes	No
Infections	Yes	No
Ear discharge	Yes	No
Nose Trauma	Yes	No
Nose obstruction	Yes	No
Snoring	Yes	No
Nasal discharge	Yes	No
Bleeding	Yes	No
Post nasal drip	Yes	No
Ringing in the ears	Yes	No

ENT

Soreness	Yes	No
Difficulty Swallowing	Yes	No
Tonsillitis	Yes	No
Voice change	Yes	No
Hoarseness	Yes	No
Sinus pain	Yes	No
Sinus swelling	Yes	No
Sinus pressure	Yes	No
Frequent sinus Infec.	Yes	No
Crowns	Yes	No
Root canals	Yes	No
TMJ	Yes	No
Dental trauma	Yes	No

OPTHALMOLOGY

Blurring vision	Yes	No
Double vision	Yes	No
Decreased visual Acuity	Yes	No

RESPIRATORY

Coughing up blood	Yes	No
Tuberculosis	Yes	No
Shortness of breath	Yes	No
Wheezing	Yes	No

Have you ever had or do you have any of these problems?

You may mark Yes ONLY!

CARDIOLOGY

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
Recurrent UTI	Yes	No
Urinary retention	Yes	No
Urinary incontinence	Yes	No

ENDOCRINOLOGY

Thyroid disease	Yes	No
Weight loss	Yes	No
Weight gain	Yes	No
Diabetes	Yes	No
Heat/Cold intolerance	Yes	No

NEUROLOGY

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

PSYCHOLOGY

Depression	Yes	No
Anxiety	Yes	No
Mental illness	Yes	No
Alcoholism	Yes	No
Drug dependency	Yes	No
ADHD	Yes	No

GASTROENTEROLOGY

Jaundice	Yes	No
Liver disease	Yes	No
Abdominal pain	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Reflux	Yes	No
Ulcers	Yes	No

Have you ever had or do you have any of these problems?

You may mark Yes ONLY!

MUSCULOSKELETAL

Arthritis	Yes	No
Back pain	Yes	No
Neck pain	Yes	No

ALLERGY

Asthma	Yes	No
Hay fever	Yes	No
Hives	Yes	No
Eczema	Yes	No
Scratchy throat	Yes	No
AIDS	Yes	No
HIV positive	Yes	No
Immune Deficiency	Yes	No

DERMATOLOGY

Rash	Yes	No
Dry/Sensitive skin	Yes	No
Hives	Yes	No
Skin cancer	Yes	No

HEMATOLOGY/LYMPH

Easy bruising	Yes	No
Hep C	Yes	No
Swollen glands	Yes	No

SOCIAL HISTORY

Employed:	Yes	No
Alcohol	Yes	No
Recreational drug use	Yes	No
Passive smoke exp	Yes	No
Caffeine	Yes	No
Oral Tobacco	Yes	No

FAMILY HISTORY BLOOD RELATIVE

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