ENT & Allergy Specialists

Patient History Form -

CENTER FOR Surgical Care

Name_____ DOB _____ Todays Date_____

Family MD_____Referring MD_____Height_____Ft ._____Inches Weight_____ Lbs

Why are you here today?

List all Allergies to Medications

Check box if you have no drug allergies ☐

Medication	Adverse reaction

Check Box if you do not routinely take any medications ☐

If you do take medications, we will review those with you in the room.

Past Medical History: Please circle below all that apply. Check box if no medical problems ☐

Diabetes Mellitus	Hypertension	Radiation Therapy History	OTHER: Please write in below
Glaucoma	Hyperlipidemia/Cholesterol	Asthma	
Irregular Heart Beat	Chemotherapy History	Sleep Apnea	
Heart Murmur	Rheumatic Fever History	Vertigo	
MI/Heart Attack	Headache/Migraine	Meniere's Disease	
CHF/Heart Failure	Fibromyalgia	Recurrent Ear Infections	
Coronary Artery Disease	Clotting or bleeding disorder	Chronic Tonsillitis	
Stroke	Heartburn/GERD	Chronic Sinusitis	
Seizures	Keloids/Abnormal Scarring	Nasal Polyps	
Hepatitis	Thyroid Nodule	Environmental Allergies	
HIV/AIDS	Hyperparathyroidism	CPAP/BIPAP use	
Kidney Disease	COPD	Cancer	
Autoimmune disease	Emphysema	Anesthetic Complications	
Malignant Hyperthermia			

Family History

Hearing Loss	☐ No ☐ Yes
Allergies	☐ No ☐ Yes
Migraines	☐ No ☐ Yes
Heart Disease	☐ No ☐ Yes
Thyroid Disease	☐ No ☐ Yes
Bleeding Problems	☐ No ☐ Yes
Cancer	☐ No ☐ Yes
Asthma	☐ No ☐ Yes

Social History

Occupation

Alcohol Use ☐ No ☐ Yes— Drinks/Week_____

Drug use ☐ No ☐ Yes— Times/Week_____

Tobacco use ☐ Never ☐ Past use ☐ Yes

_____Packs/Day Years _____

Date Quit

Smokeless Tobacco? ☐ Never ☐ Past use ☐ Yes

Ready to Quit? ☐ No ☐ Yes

Other

Are you allergic to Latex? ☐ No ☐ Yes

Are you allergic to Eggs? ☐ No ☐ Yes

Do you wear Hearing Aids? ☐ No ☐ Yes

Name_____ DOB _____ Todays Date_____

Past Surgical History: Please list your past surgeries. **Check box if you have not had any Surgeries** ☐

Surgery	Date (Can be approximate)

Have you ever had any problems with Anesthesia? ☐ No ☐ Yes ☐ N/A

Have you or any member of your family had malignant hyperthermia? (High fever caused by anesthesia) ☐ No ☐ Yes ☐ N/A

Please circle any symptoms below that you have experienced recently. **Check box if you have no symptoms** ☐

Decreased Hearing	Snoring	Jaw Pain	Other:
Difficulty Understanding	Sore Throat	Joint Pain	
Ear Drainage	Fevers/Chills/Sweats	Rash	
Ear Pain	Headache	Eczema	
Noises in the Ear	Facial Pain	Anxiety	
Dizziness or Vertigo	Fatigue or daytime sleepiness	Depression	
Nasal Congestion	Recent & unexpected weight loss	Heat intolerance	
Nasal Drainage	Changes in vision/poor vision	Cold intolerance	
Nosebleeds	Watery or itchy eyes	Abnormal or easy bruising	
Sinus Pain	Chest Pain	Abnormal bleeding	
Sneezing	Shortness of breath with exertion	Swollen Glands	
Sense of Smell problem	Shortness of breath at rest	Hay Fever	
Difficulty Swallowing	Cough	HIV or Hepatitis C exposure	
Throat Clearing	Heartburn		
Hoarseness	Kidney Stones		

To the best of my knowledge, my information on this form is accurate and complete.

Signature of patient, parent or guardian: _____ Date:_____

Relationship to patient:_____

FOR OFFICE USE ONLY

Initial when reviewed

Date: Initials:

MD/CRNA COMMENTS AND NOTES

Surgery Scheduled: Date:

Physician:

Anesthesia Plan: P.S. I II III Signature: