ST CLOUD EAR, NOSE & THROAT

Patient Health History

Patient's Name:_____

Primary Care Physician:_____

Referring Physician: _____

1. Race (Check Only One)

- ☐ Decline to State
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Other Race

2. Ethnicity (Check Only One)

- ☐ Decline to State
- ☐ Not Hispanic/Latino
- ☐ Hispanic/Latino

3. Preferred Language (Check Only One)

- ☐ English
- ☐ Somali
- ☐ Spanish
- ☐ Other: _____

4. Medications Please list **(or provide a list of)** all current prescription and over-the-counter medications.

Name of Medication	Dose & Frequency

5. Medication Allergies Please list **(or provide a list of)** all known medication allergies.

Name of Medication	Type of Reaction

6. Mark if you have any of the following

Non-Medication Allergies ☐ None

- ☐ Foods (please list):_____
- ☐ Latex
- ☐ Contrast Dye
- ☐ Other non-medication allergies (please list):

_____

7. Have you been diagnosed with cancer?

if yes, what type(s)? year diagnosed:

_____ _____

_____ _____

_____ _____

☐ No, I have not been diagnosed with cancer

8. Mark if you've been diagnosed with any of the following:

- ☐ Migraine Headache
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Nasal Allergies
- ☐ Sleep Apnea
- ☐ Blood Clots/DVT
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Heart Stent Placed
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis ☐ active ☐ inactive
- ☐ Acid Reflux
- ☐ Hepatitis
- ☐ Stomach Ulcer
- ☐ Are you pregnant? due: _____mo. _____yr.
- ☐ Prostate Enlargement
- ☐ Renal Failure
- ☐ Stroke
- ☐ Anxiety, Chronic
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Dysfunction
- ☐ Anemia
- ☐ Hemophilia
- ☐ HIV Positive

Other Medical Diagnosis:

_____ _____

_____ _____

9. Surgeries & Hospitalizations Please list (or provide list of) any surgeries and/or hospitalizations, including dates.

_____

_____

Have you experienced any problems with anesthesia?

☐ yes ☐ no If yes, please explain: _____

Do you or a family member have a history of malignant hyperthermia (general anesthesia allergy)?

☐ yes ☐ no If yes, please explain: _____

Please continue on other side…

10. Have you had an influenza/flu shot?

- ☐ Never received the vaccine
- ☐ Received this vaccine if yes, ____mo. ____yr.
- ☐ Previously declined vaccine
- ☐ Unknown

11. Have you had the PPV (pneumonia) vaccine?

- ☐ Never received the vaccine
- ☐ Primary vaccine if yes, ____mo. ____yr.
- ☐ Unknown

12. Have you had a colonoscopy?

☐ yes ☐ no if yes, ____mo. ____yr.

13. Mark family members who have been diagnosed with any of the following:

☐ Family history not known

	Mother	Father	Brother	Sister
Thyroid Cancer	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐
Unspecified Cancer	☐	☐	☐	☐
Hearing Loss before age 20	☐	☐	☐	☐
Hearing Loss after age 20	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Bleeding/Clotting Problem	☐	☐	☐	☐

☐ No family history of significant health problems

14. Mark current use of tobacco products:

☐ None ☐ Smokeless Tobacco ☐ Cigars

☐ Cigarettes, packs per day if used (closest amount)

☐ 1/2 pack ☐ 1 pack ☐ 1 1/2 packs

☐ 2 packs ☐ 3 packs

15. Mark current use of alcoholic beverages:

(A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.)

- ☐ None
- ☐ < 12 drinks per year
- ☐ 1-13 drinks per month
- ☐ 4-14 drinks per week
- ☐ > 2 drinks per day

16. Do you use drugs recreationally? ☐ yes ☐ no

17. Mark caffeine use (coffee, tea, chocolate, cola, other caffeinated drinks):

- ☐ None
- ☐ 1 per day
- ☐ 2-3 per day
- ☐ 4 or more per day

18. Are you exposed to second hand smoke?

☐ yes ☐ no

21. Home living situation (mark all that apply):

- ☐ alone
- ☐ with spouse
- ☐ with children
- ☐ with mother
- ☐ with father
- ☐ in assisted living
- ☐ in nursing home
- ☐ other

22. Mark if you have or have recently had any of the following:

- ☐ fever
- ☐ sleeping problems
- ☐ unintentional weight gain
- ☐ unintentional weight loss
- ☐ blurred vision
- ☐ itchy eyes
- ☐ loss of vision
- ☐ eye pain
- ☐ dizziness
- ☐ ear drainage
- ☐ hearing loss
- ☐ ear pain
- ☐ ringing in ears or head noise
- ☐ nasal congestion
- ☐ nosebleeds
- ☐ post-nasal drainage
- ☐ belching sour material into throat
- ☐ hoarseness or other voice change
- ☐ ulcers
- ☐ use of partials or dentures
- ☐ blacking out or fainting
- ☐ chest pain
- ☐ heart murmur
- ☐ irregular/fast/pounding heartbeat
- ☐ leg cramps/pain when walking
- ☐ swelling including ankles or legs
- ☐ non-productive cough
- ☐ productive cough
- ☐ shortness of breath/difficulty breathing
- ☐ excessive snoring
- ☐ wheezing
- ☐ abdominal pain
- ☐ diarrhea
- ☐ heartburn or indigestion
- ☐ nausea
- ☐ swallowing difficulty
- ☐ painful swallowing
- ☐ vomiting
- ☐ joint pain
- ☐ stiffness in joints
- ☐ joint swelling
- ☐ change in smell
- ☐ change in taste
- ☐ headache
- ☐ severe facial pain
- ☐ seizures
- ☐ tremor
- ☐ increased appetite
- ☐ excessive fatigue
- ☐ feeling cold
- ☐ excessive bleeding after injury
- ☐ easy bruising
- ☐ axillary masses
- ☐ groin masses
- ☐ neck masses
- ☐ hives
- ☐ sneezing
- ☐ **I DO NOT HAVE ANY OF THE ABOVE SYMPTOMS**