St Cloud Ear, Nose & Throat Clinic Patient Health History

Race (Circle Only One)	Language (Circle Only One)	
Decline to specify	English	Somali
American Indian or Alaska Native	Spanish	Other: ________
Asian	**Ethnicity (Circle Only One)**	
Black or African American	Decline to specify	
Native Hawaiian or Other Pacific	Hispanic or Latino	
White	Non-Hispanic or Latino	
Other Race		

Patient's Name: ______________________

Patient Date of Birth: ____________________

Primary Care Physician: __________________

Referring Physician: ______________________

Medications

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

Name of Medication	Dose & Frequency
______________________________________	____
______________________________________	____
______________________________________	____
______________________________________	____

Medication Allergies

Please list (provide a list of) all known medication allergies.

Name of Medication	Type of Reaction
______________________________________	____

Past Medical History – Mark if you've been diagnosed with any of the following:

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Clots/DVT
- ☐ Bleeding Disorders
- ☐ Cancer (type) ________ __________________
- ☐ Cataracts
- ☐ Chronic Bronchitis
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis (type) ___
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Migraines
- ☐ Nasal Allergies
- ☐ Currently Pregnant
- ☐ Prostate Enlargement
- ☐ Reflux
- ☐ Renal Failure/Kidney disease
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Transplant recipient

Other Medical Diagnosis:

____

____

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

☐ Heart Stent ☐ Pacemaker ☐ Defibrillator ☐ LVAD

Other Surgeries/Hospitalizations:

____

____

Have you experienced any problems with anesthesia?

☐ **Yes** ☐ **No** **If yes, explain:** ____

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

☐ **Yes** ☐ **No** **If yes, please explain:** _______________________________________

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Social History

Home living situation:

- ☐ Alone ☐ w/Spouse ☐ w/Children
- ☐ Nursing Home ☐ w/Mother ☐ w/Father
- ☐ Assisted living ☐ Other

Caffeine Intake:

- ☐ 0 drinks per day ☐ 1-3 drinks per day
- ☐ 2-4 drinks per day ☐ 5+ drinks per day

Alcohol Use:

- ☐ No use
- ☐ Socially

Current Use:

- ☐ 1-3 drinks per week
- ☐ 2-4 drinks per week
- ☐ 6+ drinks per week

Tobacco Use

Status

- ☐ Never smoked
- ☐ Former smoker, date quit: _________
- ☐ Current smoker
  - Amount (PPD): ________
  - Duration (yrs): _________

Are you exposed to secondhand smoke?

☐ Yes ☐ No

Do you use drugs recreationally?

☐ Yes ☐ No

Mark if you have any of the following Non-Medication Allergies ☐ **None**

- ☐ Adhesive tape ☐ Metal
- ☐ Iodine ☐ Contrast Dye
- ☐ Latex ☐ Food (please list):

____

____

Family Medical History

- ☐ No family history of significant issues
- ☐ Family history unknown

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

Have you received 2 doses of Covid vaccine? Yes / No

Dates 1st Dose: ___________ 2nd Dose: _____________

Review of Systems (ROS)

- ☐ Fatigue
- ☐ Fever
- ☐ Sleeping problems
- ☐ Unintentional weight loss
- ☐ Blurred vision
- ☐ Itchy eyes
- ☐ Pain in one or both eyes
- ☐ Dizziness
- ☐ Ear drainage
- ☐ Hearing loss
- ☐ Itchy ears
- ☐ Ear pain/pressure
- ☐ Ringing in ears
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Postnasal drainage
- ☐ Sneezing
- ☐ Blacking out/fainting
- ☐ Chest pain
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Vomiting
- ☐ Change in smell/taste
- ☐ Headache
- ☐ Facial pain
- ☐ Bleeds/bruises easily
- ☐ Mass in armpit
- ☐ Mass in neck
- ☐ Cough
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Wheezing

☐ **I do not have any of the above symptoms.**

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