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	
Black or African American	**Ethnicity (Circle Only One)**
Native Hawaiian or Other Pacific	Decline to specify
White	Hispanic or Latino
Other Race	Non-Hispanic or Latino

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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