Meadowcrest ENT Health History Form

Today's Date ____ /____ / ____

Name _____ M / F Birth Date ____ /____ / ____

This form is to be updated annually. Please complete this form as accurately and honestly as possible.

List all current medications and dosages, including vitamins and herbal supplements that you are taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List all known allergies to medicines, latex and environmental elements that you have:

_____ _____
_____ _____
_____ _____

Check any current medical illnesses that you have:

____ Diabetes
____ High Cholesterol
____ High Blood Pressure
____ Thyroid Disease
____ Heart Disease
____ Lung Disease
____ Blood Disorders
____ Kidney Disease
____ History of Cancer
____ Pacemaker
____ Epilepsy / Seizure Disorder
____ Other _____

List any past medical illnesses including unusual childhood illnesses and major injuries/accidents:

_____ _____
_____ _____
_____ _____

List all surgeries that you've had in the past and the dates that they were done:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Check all symptoms that you have now or have had in the past:

____ Fever
____ Masses or Lumps in Neck
____ Poor Sense of Smell
____ Insomnia
____ Bloody Sputum
____ Change in Voice
____ Fatigue
____ Difficulty Hearing
____ Dryness in Mouth or Nose
____ Skin Rash
____ Ear Pain
____ Frequent Cough or Throat Clearing
____ Unusual Insect Bite
____ Ear Drainage
____ Bad Breath
____ Trouble Healing
____ Ringing in Ears
____ Swollen Glands in Neck
____ Bruise Easily
____ Itchy Ears
____ Nasal and Sinus Drainage
____ Bleed More Than Normal
____ Nose Bleeds
____ Sores in Mouth
____ Mitral Valve Prolapse
____ Nasal Congestion
____ Difficulty Swallowing
____ Night Sweats
____ Nasal Polyps
____ Episodes of Dizziness
____ Sudden Hearing Loss
____ Reflux or Frequent Heartburn

Please answer the following questions:

Who do you live with? _____

Have you been advised to take antibiotics prior to surgery? Yes / No

Is there a family history of sudden hearing loss? Yes / No
If yes, specify what the problem was _____

Is there a family history of problems with general anesthesia? Yes / No
If yes, specify what the problem was _____

Have you had any problems with general or local anesthesia? Yes / No
If yes, specify what the problem was _____

Have you had excessive bleeding after surgeries? Yes / No
If yes, specify what the problem was _____

Do you smoke or use other tobacco products? Yes / No
Did you smoke or use other tobacco products in the past? Yes / No
If yes, specify what, how much and how often _____
If no, how long did you use tobacco products and when did you quit? _____

Do you drink alcohol? Yes / No
Did you drink alcohol in the past? Yes / No
If yes, specify what, how much and how often _____
If no, how long did you drink and when did you quit? _____

Do you use drugs? Yes / No
Did you use drugs in the past? Yes / No
If yes, specify what, how much and how often _____
If no, how long did you use drugs and when did you quit? _____

Are you or have you been exposed to any chemicals, loud noise, or other environmental hazards at home or at work? Yes / No
If yes, specify what, how much and how often _____
If no, how long were you exposed and when did that change? _____

Is your mother deceased? Yes / No
If yes, specify cause of death _____
If no, specify any medical conditions they have _____

Is your father deceased? Yes / No
If yes, specify cause of death _____
If no, specify any medical conditions they have _____

Are any of your brothers or sisters deceased? Yes / No
If yes, specify cause of death _____
If no, specify any medical conditions they have _____

Are any of your children deceased? Yes / No
If yes, specify cause of death _____
If no, specify any medical conditions they have _____