CENTURY ENT GENERAL HISTORY

Name _____ DOB: _____

Address _____

City _____State_____Zip _____

Home Phone_____Cell Phone_____Work Phone_____

Social Security No. _____ Ht. _____ Wt. _____

Race _____ Language _____ Ethnicity _____

E-mail address _____

Primary Care Physician _____ Referring Physician _____

Pharmacy Name _____

Pharmacy Location _____

Pediatric Patients Only: Are immunizations up to date?_____

Birth Weight: _____lbs. _____ounces Was he/she premature? _____

If he/she is an infant, is he/she bottle-fed _____ breast-fed _____.

Please check any of the following medical conditions that apply to you:

Allergic rhinitis _____
Anemia _____
Angioedema_____
Arrhythmia _____
Arthritis_____
Asthma _____
Auto-immune disorder _____
Clotting/bleeding problems _____
COPD _____
Dementia _____
Diabetes _____
Dizziness/balance problem _____
Downs Syndrome _____
DVT/PE _____
Dysphagia _____
Fibromyalgia _____
Glaucoma _____
Headaches _____
Heart attack _____
Heart valve disorder _____
Hepatitis _____
High blood pressure _____
Heart failure _____
HIV _____
High cholesterol _____
Hyperthyroidism _____
Joint replacement _____
Keloids _____
Kidney failure _____
Liver disease _____
Mental illness/anxiety _____ Type: _____
MRSA _____
Multiple Sclerosis _____
Organ transplant _____
Pacemaker/defibrillator _____
Reflux disease _____
Sarcoidosis _____
Seizures _____
Sickle cell disease _____
Stroke _____
TB _____

Cancer _____ Type:_____ Date of Diagnosis:_____

Cancer _____ Type:_____ Date of Diagnosis:_____

Thyroid disease _____ Type: _____

Other: _____

Current list of medications: _____

_____

List any ALLERGIES to medications, iodine, or latex with allergic reaction: _____

_____

Social History:

Do you smoke? _____ How much: _____ How often: _____

Have you ever smoked? _____

Do you drink alcohol? _____ How much: _____ How often: _____

Surgical History:

Please check any ENT surgeries you have had:

Tonsils & Adenoids _____ Myringotomy &Tubes _____ Sinus surgery _____

Septoplasty _____ Cleft lip/palate _____ Tracheotomy _____

Ear surgery: _____ Type:_____

Neck surgery: _____ Type: _____

Throat surgery: _____ Type: _____

Voice box surgery: _____ Type: _____

Thyroid surgery: _____ Type: _____

Please check any areas that apply to your family history:

Anesthesia problems: _____ Clotting/bleeding disorder: _____

Hearing loss: _____ Thyroid disease: _____

Head and neck cancer: _____ Environmental allergies: _____

Review of systems: Please check all that apply to you.

Headaches _____ Hemoptysis _____

Migraines _____ Persistent cough _____

Bleeding problem _____ Chest pain _____

Easy bruising _____ Difficult urination _____

Environmental allergies _____ Excessive scarring _____

Immune problems _____ Eczema _____

Visual changes or double vision _____ Snoring _____

Disruptive breathing at night _____ Numbness/pain/tingling extremities _____