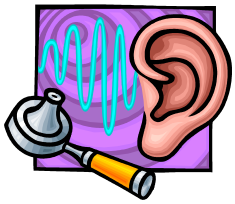

BJACH ENT New Patient Health History

Demographics

Patient name: _____ Last 4 of Sponsor's SSN: _____

Parent name (if pediatric patient):_____

Age: _____ DOB: _____ Phone number: _____

Chief Complaint (What brings you to see ENT doctor today?):_____

Medical problems/major injuries (childhood/adulthood):

_____

_____

_____

Surgical history (childhood/adulthood):

_____

_____

_____

Medications (Include prescribed medications, over-the counter medications, dietary supplements/vitamins/herbal medications):

_____

_____

_____

_____

Allergies (Include to medication/food/environmental):

_____

Social History:

- Do you drink alcohol? _____ If yes, how much and for how long?_____
- Do you smoke cigarettes? _____ Have you ever? _____
  - If yes, how much and for how long? _____ When did you Quit? _____
- Do you use chewing tobacco? _____ If yes, how much and for how long? _____
- Occupation?_____

Family History (List major illnesses, bleeding disorders, problems with anesthesia, history of head/neck cancer, childhood hearing loss or other ENT problems in first degree relatives):

_____

_____

_____

Review of Systems:

General	Yes	No
Weight gain/loss	○	○
Fever	○	○
Change in appetite	○	○
Night sweats	○	○

Skin	Yes	No
Rash or excessive bruising	○	○
Lump or growth on skin	○	○
History of skin cancer	○	○

Eyes	Yes	No
Wear glasses	○	○
Changes in vision	○	○

Ears, Nose, Throat, Mouth	Yes	No
Difficulty or changes in hearing	○	○
Earaches	○	○
Discharge from ears	○	○
Buzzing or ringing in ears	○	○
Nose stuffiness or running	○	○
Recurrent sore throat	○	○
Persistent hoarseness	○	○
Sinus problems	○	○
Frequent nose bleeds	○	○
Snoring	○	○

Genitourinary	Yes	No
Frequent urination	○	○
Difficulty emptying bladder	○	○

Musculoskeletal	Yes	No
Weakness in extremities	○	○
Numbness in extremities	○	○

Neuropsychiatric	Yes	No
Anxiety	○	○
Frequent or severe headaches	○	○
Dizziness or faintness	○	○

Cardiovascular	Yes	No
Chest pain	○	○
Shortness of breath	○	○

Respiratory	Yes	No
Cough	○	○
Blood in sputum	○	○

Endocrine	Yes	No
Fatigue	○	○
Change in heat or cold tolerance	○	○

Gastrointestinal	Yes	No
Frequent heartburn/indigestion	○	○
Nausea or vomiting	○	○

Allergic/Immunologic	Yes	No
Hayfever	○	○
Hives	○	○
Immunodeficiency	○	○
Use of nasal sprays	○	○

Hematologic/Lymphatic	Yes	No
Anemia	○	○
Excessive Bleeding or Bruising	○	○
Blood Transfusion	○	○

Pediatric patients only:

- Brief birth history (full term, ventilator requirement, NICU stay, major illnesses/medications at birth)

  _____

  _____
- Daycare?_____ Breast/bottlefed?_____ Immunizations up to date?_____
- History of hospitalizations?_____
- Does anyone in the child's household or with frequent contact with the child smoke? _____