

Confidential Health History **Ear, Nose & Throat Clinics of San Antonio**

Date of Service:	Doctor:	Med Rec #:
Patient Name:		DOB: <span style="margin-left: 20px;">Age:</span>
PCP/Referring Physician:	Height:	Weight: <span style="margin-left: 20px;">Gender:</span> <input type="checkbox"/> Male <input type="checkbox"/> Female

What is your reason for today's visit?

**PAST HISTORY**

SURGERY	Date(s)	Y	N	ILLNESS	Date(s)	Y	N	List any medications you are taking:
Abdominal		<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder		<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure		<input type="checkbox"/>	<input type="checkbox"/>	
Appendix		<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease / Hepatitis		<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid		<input type="checkbox"/>	<input type="checkbox"/>	Nervous System		<input type="checkbox"/>	<input type="checkbox"/>	
Rectal		<input type="checkbox"/>	<input type="checkbox"/>	Stomach, Intestine		<input type="checkbox"/>	<input type="checkbox"/>	
Tonsils		<input type="checkbox"/>	<input type="checkbox"/>	Kidney, Bladder		<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy		<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease		<input type="checkbox"/>	<input type="checkbox"/>	
Pregnancy		<input type="checkbox"/>	<input type="checkbox"/>	Cancer		<input type="checkbox"/>	<input type="checkbox"/>	
Breast		<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems/Tuberculosis		<input type="checkbox"/>	<input type="checkbox"/>	
Other		<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol		<input type="checkbox"/>	<input type="checkbox"/>	
<b>ALLERGIES:</b>				Heart Disease		<input type="checkbox"/>	<input type="checkbox"/>	
				Blood or Clotting System		<input type="checkbox"/>	<input type="checkbox"/>	
				Ear, Nose, Mouth, Throat		<input type="checkbox"/>	<input type="checkbox"/>	
				Thyroid Gland		<input type="checkbox"/>	<input type="checkbox"/>	

**SOCIAL HISTORY**

Y  N Do you / did you ever drink alcohol?

Y  N Do you / did you ever use tobacco?      If Yes, Type: \_\_\_\_\_      When did you stop: \_\_\_\_\_

Y  N Do you / did you ever use drugs?

Y  N Do you / did you ever use any nutritional supplements?

Y  N Do you / did you ever have a sexually transmitted disease?

Marital Status (circle one):    Single                  Married                  Widowed                  Divorced                  Partnered                  Engaged                  Separated

Occupation (If retired, please list previous occupations and current activities): \_\_\_\_\_      Date stopped working:      /      /

**FAMILY HISTORY**      Check (✓) if your blood relatives have had any of the following:

DISEASE	Y	N	Relationship	DISEASE	Y	N	Relationship
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	

<b>PHARMACY NAME:</b>	<b>PHONE:</b>

Patient Name:	Date:
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**REVIEW OF SYSTEMS** Check (✓) symptoms you currently have.

<b>CONSTITUTIONAL</b>	<b>CARDIOVASCULAR</b>	<b>NEUROLOGIC</b>
<input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Chills <input type="checkbox"/> Dizziness <input type="checkbox"/> Weight Loss <input type="checkbox"/> Bleeding/Bruising Easily	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Swelling <input type="checkbox"/> Blood Clots	<input type="checkbox"/> Seizure <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Paralysis <input type="checkbox"/> Disorientation <input type="checkbox"/> Tremor <input type="checkbox"/> Numbness Extremities
<b>EYES</b>	<b>RESPIRATORY</b>	<b>PSYCHIATRIC</b>
<input type="checkbox"/> Visual Disturbance <input type="checkbox"/> Cataract <input type="checkbox"/> Double Vision <input type="checkbox"/> Trauma <input type="checkbox"/> Glaucoma <input type="checkbox"/> Eye Pain	<input type="checkbox"/> Shortness Of Breath <input type="checkbox"/> Orthopnea <input type="checkbox"/> Cough <input type="checkbox"/> PND <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Chest Congestion	<input type="checkbox"/> Confusion <input type="checkbox"/> Anxiety <input type="checkbox"/> Paranoia <input type="checkbox"/> Insomnia <input type="checkbox"/> Disorientation <input type="checkbox"/> Mood Changes <input type="checkbox"/> Depression
<b>ENT</b>	<b>GI (Abdominal Symptoms)</b>	<b>ENDOCRINE</b>
<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Jaw Swelling <input type="checkbox"/> Earache <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Ringing In Ears <input type="checkbox"/> Voice Changes <input type="checkbox"/> Dizziness <input type="checkbox"/> Nosebleed <input type="checkbox"/> Ear Drainage <input type="checkbox"/> Congestion <input type="checkbox"/> Ear Swelling <input type="checkbox"/> Nose Drainage <input type="checkbox"/> Sore Throat <input type="checkbox"/> Nose Pain <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Swelling <input type="checkbox"/> Toothache <input type="checkbox"/> Nose Trauma	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation <input type="checkbox"/> Gas/Bloating <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bleeding	<input type="checkbox"/> Growth Abnormalities <input type="checkbox"/> Goiter <input type="checkbox"/> Heat/Cold Intolerance <input type="checkbox"/> Impotence <input type="checkbox"/> Excessive Thirst/Hunger
<b>NECK</b>	<b>GU (Problems with Urination)</b>	<b>HEMATOLOGY</b>
<input type="checkbox"/> Swollen Nodes <input type="checkbox"/> Stiffness <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Trauma	<input type="checkbox"/> Urination Problem <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Blood In Urine <input type="checkbox"/> Vaginal Bleeding <input type="checkbox"/> Leg Pain <input type="checkbox"/> Scrotal Pain/Swelling	<input type="checkbox"/> Bleeding <input type="checkbox"/> Anemia <input type="checkbox"/> Bruising
<b>SKIN</b>	<b>MUSCULOSKELETAL</b>	<b>ALLERGY IMMUNOLOGY</b>
<input type="checkbox"/> Rash <input type="checkbox"/> Bruising <input type="checkbox"/> Lesions <input type="checkbox"/> Itching	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Urticaria <input type="checkbox"/> Hay Fever <input type="checkbox"/> Eczema <input type="checkbox"/> Sensitivity to Food/Drugs/Pollen
	<b>OTHER</b>	

**GENERAL CONSENT FOR TREATMENT**

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instruction of Dr. \_\_\_\_\_, his/her assistants or his/her designee as is necessary in his/her judgement.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examinations by Dr. \_\_\_\_\_.

**VERIFICATION**

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Form Completed By:     Patient       Physician       Office Nurse       Medical Assistant      (name or initials)

Patient Signature:	Date:
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Physician Signature:	Date Reviewed By Physician:
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