

**TRI-STATE OTOLARYNGOLOGY
HEAD AND NECK SURGERY, INC.**

HEALTH HISTORY FORM

NAME _____ SOC. SEC. # _____

Past Medical History

ALLERGIES: (Medications or drugs) _____ (food) _____

List all medications or sprays you are currently taking: _____

List all previous surgeries with year performed: _____

List any serious past illnesses: _____

Family History

Has your immediate family had (circle or write relationship beside item)

Asthma	Hearing Loss	Bleeding problems	Diabetes
Sickle cell anemia	Anesthesia Reaction	Cancer	Thyroid Disease

Social History

Do you use tobacco products? _____ What Type? _____ How often? _____ Have you ever used tobacco products? _____

How much alcohol do you drink per week? _____ Did you ever drink excessively? _____

Specifically, have you ever had? (Circle)

Fatigue	Night Sweats	Sickle cell anemia
Cataracts	Heart Trouble	Unintentional Weight Change
Bronchitis	Positive TB Test	High Blood Pressure
Stomach Ulcers	Reflux	Emphysema
Prostate trouble	Arthritis	Kidney infections
Anxiety	Nervous Breakdown	Seizures
Thyroid trouble	Head Injury (unconscious)	Depression
		Hepatitis or Liver Trouble
		Glaucoma
		Rheumatic Fever
		Diabetes
		Bleeding Problems
		Stroke
		Syphillis
		AIDS

Have you or are you having any of the following:

(check yes or no)	(answer in blanks)	(circle appropriate side)	
YES / NO			
___/___	Difficulty in hearing?	Right	Left Both
___/___	When did it start? _____		
___/___	Noise in ears? How Long? _____	Right	Left Both
___/___	Please describe the noise _____		
___/___	Fullness or stuffiness in ears?	Right	Left Both
___/___	Pain in your ears?	Right	Left Both
___/___	Drainage from your ears?	Right	Left Both
___/___	Injury to your ears?	Right	Left Both
___/___	Loud noise exposure?	Right	Left Both
___/___	Have you had Antibiotics by INJECTION for 1 or more weeks?		
___/___	Do you wear a hearing aid? Which ear? _____	Right	Left Both
___/___	Is the hearing aid helpful? _____		
___/___	Bad bite or bad teeth _____		
___/___	Do you wear dentures? _____		
___/___	Difficulty breathing through your nose?	Right	Left Both
___/___	Nasal drainage? Which side? _____	Right	Left Both
___/___	The Drainage is (circle) Clear _____	Yellow/Green	Bloody
___/___	Sinus infection? _____		
___/___	Nasal injuries? If yes, please explain _____		
___/___	When? _____		
___/___	Throat or tonsil infection? _____		
___/___	Difficulty swallowing? Explain _____		
___/___	Hoarseness? How often? _____		
___/___	Pain or swelling in the neck? _____		
___/___	Do you have hayfever? Asthma? _____	Exzema? _____	
___/___	Do you snore? _____ Sneeze? _____	Cough? _____	
___/___	Dizziness? _____		

Physician's Signature _____ Date _____