Ridgeview CLINICS

PATIENT HEALTH HISTORY

Ridgeview Otolaryngology

Place Patient Label Here

Full **LEGAL** Name: _____ M ☐ F ☐

Pharmacy Preference: _____ Location: _____

Primary Care (Family) Physician: _____ Date of Birth: _____

Referring Physician: _____ Date of Appointment: _____

Is our office authorized to leave detailed messages for you on your voicemail or with anyone in your home? No ☐ Yes ☐ Number: _____

E-mail Address: _____

Please list the <u>main reason</u> you are seeing an ENT specialist: _____

How long have you had this condition: _____

<u>CURRENT REVIEW OF SYMPTOMS</u> Please ✓ the box if ***<u>currently</u>*** experiencing

☐ Fever	☐ Nasal Congestion	☐ Wheezing	☐ Fainting
☐ Fatigue	☐ Sore Throat	☐ Abdominal Pain	☐ Difficulty Walking
☐ Facial Pain	☐ Hoarseness	☐ Nausea	☐ Irritable
☐ Facial Pressure	☐ Acid Reflux	☐ Vomiting	☐ Anxiety
☐ Itchy Eyes	☐ Post Nasal Drainage	☐ Diarrhea	☐ Depression
☐ Watery Eyes	☐ Snoring	☐ Muscle Aches	☐ Generalized Weakness
☐ Blurred Vision	☐ Heart Palpitations	☐ Lesion	☐ Swollen Glands
☐ Ear Pain	☐ Chest Pain	☐ Rash	☐ Easy Bleeding
☐ Hearing Loss	☐ Cough	☐ Headaches	☐ Easy Bruising
☐ Ear Ringing	☐ Shortness of Breath	☐ Dizziness	☐ Other _____

<u>PAST HEALTH HISTORY</u> Please ✓ the box if ***<u>you have been diagnosed with any of the following:</u>***

☐ Cancer: (Type) _____

	DATE
☐ Hearing Loss	_____
☐ Dizziness	_____
☐ Nasal Allergies	_____
☐ Recurrent Nosebleeds	_____
☐ Recurrent Tonsillitis	_____
☐ Tonsil Stones	_____
☐ Elevated Cholesterol	_____
☐ High Blood Pressure	_____
☐ Heart Valve Defect	_____
☐ Stroke	_____
☐ Tuberculosis	_____
☐ Asthma	_____
☐ Crohns Disease	_____
☐ Acid Reflux	_____
☐ Stomach Ulcer	_____

	DATE
☐ Ulcerative Colitis	_____
☐ Kidney Failure	_____
☐ Depression	_____
☐ Anxiety	_____
☐ Diabetes I ☐ or Diabetes II ☐	_____
☐ Thyroid Disease	_____
☐ Infectious Mononucleosis	_____
☐ HIV	_____
☐ Hepatitis Type: _____	_____
☐ MRSA/Drug-Resistant Infection	_____
☐ Anemia	_____
☐ Bleeding/Clotting Problems	_____
☐ Rheumatoid Arthritis	_____
☐ Other _____	_____

SURGERIES AND HOSPITALIZATIONS

Have you ever had any complications with anesthesia (being numbed up or put to sleep)? No ☐ Yes ☐ _____

Have you ever undergone ear, nose or throat surgery? No ☐ Yes ☐ _____

Please list any other surgeries or hospitalizations with the dates: _____

_____

FAMILY HISTORY

Hearing Loss ☐ Mother ☐ Father ☐ Brother ☐ Sister
Ear Infections ☐ Mother ☐ Father ☐ Brother ☐ Sister
Nasal Allergies ☐ Mother ☐ Father ☐ Brother ☐ Sister
Asthma ☐ Mother ☐ Father ☐ Brother ☐ Sister

Heart Disease ☐ Mother ☐ Father ☐ Brother ☐ Sister
High Blood Pressure ☐ Mother ☐ Father ☐ Brother ☐ Sister
Stroke ☐ Mother ☐ Father ☐ Brother ☐ Sister
Bleeding/Clotting Problem ☐ Mother ☐ Father ☐ Brother ☐ Sister

Anesthesia Complications (type) _____ ☐ Mother ☐ Father ☐ Brother ☐ Sister

Cancer (type) _____ ☐ Mother ☐ Father ☐ Brother ☐ Sister

Other _____ ☐ Mother ☐ Father ☐ Brother ☐ Sister

SOCIAL HISTORY

Currently Working ☐ Disabled ☐ Unemployed ☐ Retired ☐

Do you currently use tobacco? No ☐ Yes ☐ Year started: _____ Cigarettes per day: _____

Are you a former tobacco user? No ☐ Yes ☐ Year started: _____ Year quit: _____ Average daily use: _____

Are you exposed to second hand smoke? No ☐ Yes ☐

Do you consume alcohol? No ☐ Yes ☐ Describe: _____

Are you ALLERGIC to medication? None ☐ Yes ☐

Name of Medication	**Reaction**

Are you ALLERGIC to anything such as pollens, dust, food, insects, etc.? No ☐ Yes ☐ _____

Have you ever had an allergy test? No ☐ Yes ☐

Are you allergic to latex? No ☐ Yes ☐ **Are you allergic to contrast dye?** No ☐ Yes ☐

List Any Medications You Take (prescription, over-the-counter, vitamins or herbal): None ☐

Name of Medication	**Dosage**	**How Often Taken**

The above information is accurate to the best of my knowledge _____ **Date:** _____

(Signature of Patient/Legal Guardian)