EAR, NOSE & THROAT SPECIALISTS
of Northern Virginia, P.C.

Health History

Patient Name _____ D.O.B. _____/____/_____ Age____

Reason of visit _____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

VITALS: HEIGHT: ___ft ___in WEIGHT: ____lbs (**OFFICE USE ONLY**) BP_____PULSE: _____

1. **PAST MEDICAL HISTORY** – Have you ever had the following**:** **__No Significant Past Medical History**

☐ ALLERGIC RHINITIS	☐ DIABETES	☐ HYPERTENSION	☐ SINUSITIS
☐ ARTHRITIS	☐ ECZEMA	☐ MENIERE'S DISEASE	☐ SNORING
☐ ASTHMA	☐ ELEVATED CHOLESTEROL	☐ MIDDLE EAR INF	☐ STROKE
☐ AUTOIMMUNE DISORDER	☐ EPISTAXIS	☐ MIGRAINES	☐ TMJ
☐ CANCER (type)_____	☐ HIV	☐ NASAL INJURY	☐ THYROID DIS
☐ CERUMEN (WAX)	☐ HEARING LOSS	☐ NASAL POLYPS	☐ TONSILLITIS
☐ CHOLESTEATOMA	☐ HEAD INJURY	☐ PHARYNGITIS	☐ OTHER_____
☐ DEVIATED NASAL SEPTUM	☐ HEART ATTACK	☐ SLEEP APNEA	

2. **PAST SURGICAL HISTORY** – Have you ever had the following: **__No Significant Past Surgical History**

☐ Sinus Surgery ☐ Tonsil /Adenoid ☐ Ear Surgery ☐ Ear Tubes ☐ Thyroid/Neck Surgery
☐ Vocal/Larynx Surgery ☐ Cervical Spine Surgery Other_____
_____ _____ _____

3. **CURRENT MEDICATIONS: (INCLUDING OVER THE COUNTER) STRENGTH AND DOSAGE** **__No Medications**

_____ _____ _____
_____ _____ _____
_____ _____ _____

4. **Please list all ALLERGIES (food, drugs, and environment)** **__No Allergies**

_____ _____ _____
_____ _____ _____
_____ _____ _____

5. **FAMILY HISTORY:** **__No Family History of Problems**

	Relationship		Relationship
☐ CANCER	_____ what type of cancer? _____		
☐ NEUROLOGY DISORDER	_____	☐ DIABETES	_____
☐ HEARING LOSS	_____	☐ STROKE	_____
☐ HEART DISEASE	_____	☐ KIDNEY PROBLEMS	_____
☐ HYPERTENSION	_____	☐ BLEEDING PROBLEMS	_____

6. SOCIAL HISTORY:

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Tobacco: ☐ Never ☐ Former Smoker (quit ____yrs ago) ☐ Active everyday (__ packs/day x___ yrs) ☐ Minimal

Alcohol: ☐ Never ☐ Social ☐ less than 10 per week ☐ more than 10 per week

7. REVIEW OF SYSTEMS: PLEASE MARK THE SYMPTOMS YOU CURRENTLY HAVE OR HAD WITHIN THE PAST 6 MONTHS.

Constitutional:	**fever**	**fatigue**	**poor appetite**		
Eyes:	**vision change**	**dry eyes**	**excessive tearing**		
HENT:	**headache**	**vertigo**	**dizziness**	**dental problems**	**ear pain**
	Hearing loss	**ringing in ears**	**pulse in ear**	**ear discharge**	**pressure in ear**
	itching in ear	**nasal congestion**	**nose bleeding**	**sinus pain**	**post nasal drip**
	decreased smell	**runny nose**	**nasal obst**	**sore throat**	**mouth ulcers**
	enlarged tonsils	**hoarseness**	**lump in throat**	**white spots in mouth**	
Cardiovascular:	**chest pain**	**syncope**	**irregular heartbeats**		
Respiratory:	**wheezing**	**snoring**	**shortness of breath**		
Gastrointestinal:	**nausea**	**heartburn**	**difficulty swallowing**	**excessive belching**	
Integument:	**rash**	**dry skin**	**itching**		
Neurological:	**seizure**	**tremors**	**tingling or numbness**	**muscular weakness**	**memory loss**
Musculoskeletal:	**back pain**	**joint pain**	**neck pain**	**swelling**	
Endocrine:	**weight gain**	**weight loss**	**cold intolerance**	**hot intolerance**	
Psychiatric:	**anxiety**	**depression**			
Blood-Lymph:	**easy bleeding**	**easy bruising**	**swollen glands**		
Allergic-Immunologic:	**food allergies**	**frequent illness**	**environmental allergies**		

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**