Ear, Nose and Throat
Specialists of Wisconsin

HEALTH HISTORY FORM

Please answer all questions.

Patient Name: _____ DOB _____ Date: _____

Today's visit is for: _____

Height: _____ Weight: _____ Referring Provider: _____

I have had the following tests done already: (X-rays, lab tests) _____

The following treatments have been tried: _____

Medications / Medical History

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

MEDICAL HISTORY / CURRENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY, FILL IN ANY OTHERS)

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Heart Problems: _____
- ❑ Damaged Heart Valves:_____
- ❑ High Cholesterol
- ❑ Asthma
- ❑ Infections/TB/Hepatitis/HIV_____
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Thyroid Problems: _____
- ❑ Hyper / Hypo (circle) Thyroid
- ❑ Stomach/GI/Reflux:_____
- ❑ Cancer, type:_____
- ❑ Sleep Apnea:_____
- ❑ Kidney:_____
- ❑ _____

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:

SURGERIES

TYPE OF SURGERY	DATE

for FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)	
Conditions/Problems	***Immediate Family Members (parents, grandparents, siblings, children) affected and exact nature of problems***
❑ Diabetes	
❑ Heart Problems	
❑ Cancer	
❑ High Cholesterol	
❑ Malignant Hyperthermia (Anesthesia complications)	
❑ Hearing Loss Before Age 60	
❑ Bleeding/Clotting Disorder	

SOCIAL HISTORY / HABITS

❑ Smoker: _____ packs/day ❑ Non-smoker ❑ Quit smoking in _____ ❑ Occupation _____
❑ Smokeless Tobacco:_____
❑ I exercise regularly ❑ I exercise rarely ❑ I do not exercise ❑ Smoke exposure
Alcohol use: ❑ Yes (drinks/week:_____) ❑ No ❑ Pets
❑ I have traveled outside the United States in the past three months ❑ Daycare

REVIEW OF SYMPTOMS: Please mark the symptoms you've been having for the past month.

GENERAL
- ❑ weight gain
- ❑ weight loss
- ❑ loss of appetite
- ❑ fever
- ❑ weakness
- ❑ night sweats
- ❑ dry mouth
- ❑ depression
- ❑ anxiety

SKIN
- ❑ rash
- ❑ dry/sensitive skin
- ❑ hives
- ❑ new/worrisome moles
- ❑ jaundice
- ❑ redness
- ❑ swelling
- ❑ itching
- ❑ bruising

EYES
- ❑ decreased vision
- ❑ eye drainage
- ❑ blurry vision
- ❑ eye itching
- ❑ Glaucoma

RESPIRATORY
- ❑ shortness of breath
- ❑ chest tightness
- ❑ cough
- ❑ wheezing

ALLERGY
- ❑ runny nose
- ❑ scratchy throat
- ❑ itchy eyes
- ❑ ear fullness
- ❑ sinus congestion
- ❑ sneezing

EAR/NOSE/THROAT
- ❑ congestion
- ❑ cough
- ❑ coughing blood
- ❑ nosebleed
- ❑ hearing loss
- ❑ dizziness
- ❑ ringing in ears
- ❑ change in voice
- ❑ sore throat
- ❑ snoring
- ❑ ear pain
- ❑ ear drainage
- ❑ swollen tonsils
- ❑ difficulty swallowing

CARDIOLOGY
- ❑ chest pain
- ❑ palpitations
- ❑ leg swelling
- ❑ shortness of breath

GASTROENTEROLOGY
- ❑ nausea
- ❑ heartburn
- ❑ history of having colon polyps
- ❑ black tarry BM
- ❑ vomiting
- ❑ abdominal pain
- ❑ diarrhea

MUSCULOSKELETAL
- ❑ joint stiffness
- ❑ leg cramps
- ❑ joint pain
- ❑ joint swelling
- ❑ back pain
- ❑ neck pain
- ❑ jaw pain

NEUROLOGY
- ❑ headache
- ❑ tingling/numbness
- ❑ seizures
- ❑ memory loss
- ❑ problems walking
- ❑ tremors/shaking

BLOOD/LYMPH
- ❑ swollen glands
- ❑ fatigue
- ❑ loss of appetite
- ❑ easy bruising

ENDOCRINE
- ❑ fatigue
- ❑ excessive sweating
- ❑ excessive thirst
- ❑ excessive urination
- ❑ sleep problems
- ❑ heat intolerance
- ❑ cold intolerance
- ❑ lump in neck or thyroid

For Official Use only

Provider initials: _____ Date: _____