



# HEALTH HISTORY

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

WHO REFERRED YOU TO OUR PRACTICE? \_\_\_\_\_

REASON FOR VISIT? \_\_\_\_\_

WHAT DATE DID SYMPTOMS BEGIN? \_\_\_\_\_

### PROBLEMS (Please Check Appropriate Boxes)

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Sore Throat         |
| <input type="checkbox"/> Vertigo      | <input type="checkbox"/> Nose Congestion | <input type="checkbox"/> Snoring             |
| <input type="checkbox"/> Ear Ringing  | <input type="checkbox"/> Nose Discharge  | <input type="checkbox"/> Heartburn           |
| <input type="checkbox"/> Ear Pain     | <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Hoarseness          |
| <input type="checkbox"/> Ear Fullness | <input type="checkbox"/> Nose Bleeds     | <input type="checkbox"/> Allergies           |
| <input type="checkbox"/> Dizziness    | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Swallowing Problems |
| <input type="checkbox"/> Neck Pain    | <input type="checkbox"/> Neck Mass       |  |
| <input type="checkbox"/> Other _____  |  |  |

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

LIST ANY DRUG ALLERGIES: \_\_\_\_\_

### PAST MEDICAL HISTORY (Please Check Appropriate Boxes)

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Thyroid Disorder  | <input type="checkbox"/> Glaucoma      |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Coronary Disorder | <input type="checkbox"/> Hypertension  |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Emphysema    | <input type="checkbox"/> Kidney Disorder   | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Stroke            | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Other _____  |  |  |

### PAST SURGICAL HISTORY (Please Check Appropriate Boxes)

- |  |                                       |                                       |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Ear Tubes     | <input type="checkbox"/> Hernia       | <input type="checkbox"/> Back/Neck    |
| <input type="checkbox"/> Septoplasty   | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Appendix     |
| <input type="checkbox"/> Sinus Surgery | <input type="checkbox"/> Cataracts    | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Other _____  |                                       |

### FAMILY HISTORY (Please Check Appropriate Boxes)

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Strokes       | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Allergies         | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Lung Cancer  |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Other _____       |                                       |