

AUGUSTA ENT PC
PATIENT HEALTH HISTORY CONTINUED

(6) FAMILY HISTORY

Specific Anesthesia Problem: Mother Father Brother Sister
Ears:
 Hearing Loss before age 20 Mother Father Brother Sister
 Hearing Loss after age 20 Mother Father Brother Sister
Nose and Sinus:
 Nasal Allergies Mother Father Brother Sister
Heart and Blood Vessels:
 Heart Disease Mother Father Brother Sister
 High Blood Pressure Mother Father Brother Sister

Cancer: Mother Father Brother Sister
Lungs and Respiratory:
 Asthma Mother Father Brother Sister
 Lung Cancer Mother Father Brother Sister
Brain and Nervous:
 Stroke Mother Father Brother Sister
Blood & Lymph Node:
 Bleeding/clotting Mother Father Brother Sister
Other _____ Mother Father Brother Sister

(7) SOCIAL HISTORY

What is or was your occupation? _____ Check here if you are retired.

Have you ever used tobacco in any form? No Yes

If yes, please complete the following:

Type of Tobacco	From Year	To Year
Cigarettes per Day: _____		
Other: (list type) _____		

Are you exposed to second hand smoke? No Yes

Is there personal history of substance abuse? No Yes If yes, please explain _____

(8) REVIEW OF SYSTEMS: Have you had or have you recently had any... General health problems?

(Fever, Weight loss, Problems sleeping, Etc.) No Yes

If yes, please list _____

Eye problems that are not correctable with glasses?

(Double vision, Glaucoma, Cataracts, Etc.) No Yes

If yes, please list _____

Ear problems?

(Drainage, Hearing loss, Ringing, Dizziness, Etc.) No Yes

If yes, please list _____

Nose and Sinus problems?

(Obstruction, Congestion, Drainage Etc.) No Yes

If yes, please list _____

Mouth and Throat problems?

(Frequent sore throat, Mouth sores, Hoarseness, Etc.) No Yes

If yes, please list _____

Cardiovascular (Heart & Blood Vessel) problems?

(Blacking out, Fainting, Bluish discoloration of lips or fingernails, Chest pain, Irregular heartbeat, Swelling of legs, feet, and/or ankles, Leg cramps, Etc.) No Yes

If yes, please list _____

Respiratory (Lung & Respiratory System) problems?

(Wheezing, Shortness of breath, Productive cough, Non-Productive cough, Etc.) No Yes

If yes, please list _____

Gastrointestinal (Stomach & Digestive System) problems?

(Pain, Heartburn, Nausea, Vomiting, Diarrhea, Bleeding, Etc.) No Yes

If yes, please list _____

Do you consume alcohol? No Yes

If yes, please complete the following:

Type of Alcohol	How Much	How Often

Genitourinary (Reproductive, Kidney, Urinary Tract) problems?

(Burning, Bleeding, Change in urinary pattern, Problems passing urine, Etc.) No Yes

If yes, please list _____

Musculoskeletal (Bone, Joint, Muscle, & Neck) problems?

(Painful joints, Muscles, Bone deformities, Etc.) No Yes

If yes, please list _____

Integumentary (Skin, Breast, Hair, or Nail) problems?

(Skin rash, Sores, Tender nipples, Etc.) No Yes

If yes, please list _____

Neurological (Brain, Nervous System, & Headaches) problems?

(Seizures, Numb areas, Nerve problems, Etc.) No Yes

If yes, please list _____

Psychiatric (Mental or Emotional Health) problems?

(Depression, Anxiety, Suicidal thoughts, Etc.) No Yes

If yes, please list _____

Endocrine (Glands, Hormones, Blood Sugar Control) problems?

(Diabetes, Thyroid Deficiency, Thyroid Excess, Etc.) No Yes

If yes, please list _____

Hematologic / Lymphatic (Blood & Lymph Nodes) problems?

(Bleeding freely, Bruising excessively, other, Etc.) No Yes

If yes, please list _____

Allergic, Infectious, Immunologic (Allergies, Infections, & Immune System) problems?

No Yes

If yes, please list _____

In the last 6months, have you had any of the following tests (Sinus, Head, or Neck only):

CT Scan MRI X-Ray PET Scan Any Blood Work

If yes, where was the test performed? _____