Raza Pasha, MD / Philip A. Matorin, MD

Personal Health History Form

This form will be part of your medical record. Upon completion, please sign the last page.

Name: _____ **Date**: _____ / _____ / 20____
Last First MI

Who is your Primary Physician? _____

Have you seen an ENT physician before? Yes No Physicians Name: _____

Pharmacy Name and Phone Number: _____

The main problem that brings me to clinic is: _____

_____

Past Medical History

Check any conditions that you have or have had in the past.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ COPD/Emphysema
- ☐ Diabetes
- ☐ Migraines
- ☐ Epilepsy (seizure)
- ☐ GERD/Peptic Ulcers
- ☐ Heart disease (heart attack, CHF)
- ☐ Hepatitis or liver disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Immune deficiency
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Alcoholism/Chemical Dependency
- ☐ Psychiatric Care
- ☐ Anxiety/ Depression /Panic Attacks
- ☐ Tuberculosis
- ☐ Sleep apnea
- ☐ Kidney disease
- ☐ Thyroid disorder

Have you had Cancer? ☐ Yes ☐ No Type and Treatment? _____

Do you have any other medical conditions? _____

Could you be pregnant (women in childbearing years)? ☐ Yes ☐ No

Past Surgical History

Check any ENT procedures you have had in the past.

- ☐ Tonsillectomy/Adenoidectomy
- ☐ Septoplasty
- ☐ Voice Box (Larynx) Surgery
- ☐ Ear tubes or other Ear Surgery
- ☐ Rhinoplasty
- ☐ Sinus Surgery
- ☐ UP3 (sleep apnea surgery)

List any other surgeries or procedures?

_____

_____

Social History

Do/have you smoked? ☐ Yes ☐ No Did you quit? ☐ Yes ☐ No How long ago? _____

If so, how much and how long have/did you smoke? _____ pack(s)/day for _____ year(s)

Do/have you drink alcohol? ☐ Yes ☐ No Did you quit? ☐ Yes ☐ No How long ago? _____

If so, how much do/did you drink? _____

Have you or currently use any “street drugs”? ☐ Yes ☐ No What type? _____

Medications and Medicine Allergies

List all prescription and non-prescription medications you currently take: ☐ None

_____ Medication	_____ Medication
_____ Medication	_____ Medication
_____ Medication	_____ Medication
_____ Medication	_____ Medication

Do you take aspirin? ☐ Yes ☐ No

What medications are you allergic or have had bad reactions? ☐ None

_____ Medication _____ Medication _____ Medication

Family History

Does anyone in your family have any of the following?

☐ Cancer – What type? _____

☐ Allergies	☐ Diabetes	☐ Thyroid disease
☐ Bleeding disorders	☐ Heart disease	☐ Problems with anesthesia
☐ Cystic fibrosis	☐ Hearing Loss	

Are there any other diseases that run in your family? _____

Birth History (Patients under 12 years of age)

What type of delivery did you have? ☐ vaginal delivery ☐ cesarean delivery
☐ full term ☐ premature ____ week(s) ☐ late ____ week(s)

Were there any complications during or after delivery? ☐ none

☐ Intensive Care Stay	☐ Jaundice	☐ Meningitis	☐ Other: _____
☐ Intubated (breathing machine)	☐ Low birth weight	☐ Neonatal Infection	

Are your child's immunizations up-to-date? ☐ yes ☐ no ☐ scheduled

Review of Symptoms

Have you had any of the following in the last 48 hours?

☐ Changes in vision	☐ Fever (>100.5°)	☐ Numbness or weakness
☐ Diarrhea/Constipation	☐ Irregular heart beat	☐ Problems urinating
☐ Difficulty in breathing	☐ Muscle Aches	☐ Skin changes
☐ Feeling anxious	☐ Nausea or vomiting	☐ Unexplained weight loss

Have you had any of the following in regards to your ears? ☐ No

☐ Dizziness/Vertigo	☐ Ear drainage	☐ Ear fullness or pressure
☐ Ear pain	☐ Noise or ringing in the ears	☐ Worsening hearing

Have you had any of the following in regards to your throat? ☐ No

☐ Bad breath ☐ Difficulty Swallowing ☐ Dry mouth
☐ Gagging ☐ Hoarseness ☐ Heartburn
☐ Lump in throat ☐ Post nasal drip ☐ Pain on swallowing

Do you have problems with any of the following? ☐ No

☐ Daytime tiredness ☐ Gasping at night ☐ Mouth breathing
☐ Snoring ☐ Stop breathing at night

Please rate by circling the following symptoms from 0 (no problem) to 5 (severe problem), when you experience the symptom.

1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Cough	0	1	2	3	4	5
5. Post-nasal discharge	0	1	2	3	4	5
6. Thick nasal discharge	0	1	2	3	4	5
7. Ear fullness	0	1	2	3	4	5
8. Dizziness	0	1	2	3	4	5
9. Ear pain	0	1	2	3	4	5
10. Facial pain/pressure	0	1	2	3	4	5
11. Difficulty falling asleep	0	1	2	3	4	5
12. Wake up at night	0	1	2	3	4	5
13. Lack of sleep	0	1	2	3	4	5
14. Wake up tired	0	1	2	3	4	5
15. Fatigue	0	1	2	3	4	5
16. Reduced productivity	0	1	2	3	4	5
17. Reduced concentration	0	1	2	3	4	5
18. Frustrated/restless/irritable	0	1	2	3	4	5
19. Sad	0	1	2	3	4	5
20. Embarrassed	0	1	2	3	4	5

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the office staff responsible for errors or omissions that I may have made in completing this form.

_____ _____ - _____ - 20___
Signature of Patient Date