

Northland Ear, Nose & Throat, P.C.
Adult Medical History Form
www.northlandent.com

Today's Date

Legal Name: _____ Current Age: _____ Date of Birth: _____
 Male Female Height : _____ Weight: _____
Family Physician: _____ Referring Physician: _____

Reason for being seen today (Please list your symptoms): _____

Onset of symptoms: _____

How severe are your symptoms at this time:

- No longer present
- Mild
- Moderate
- Severe
- Disabling

List the medications used to treat your symptoms:

(Include non-prescriptions)

Current Medications (Including Non-Prescriptions):

Medication:	Dose:	How often do you take the medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History:

Do you have a history of

- | | |
|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Myocardial Infarction (heart attack) | <input type="checkbox"/> Chronic bronchitis or emphysema |
| <input type="checkbox"/> Heart rhythm problems | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Hypertension (High blood pressure) | <input type="checkbox"/> Other urinary tract disease |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis or liver disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> AIDS or HIV positive status |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Spine problems |
| <input type="checkbox"/> Cancer (please list below) | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| | <input type="checkbox"/> Other major illnesses (list) |

Comments: _____

Past Surgeries or Trauma History:

Please mark any prior surgeries and the date completed next to it.

- | | | |
|---|--|--|
| <input type="checkbox"/> Tonsillectomy/Adenoidectomy | <input type="checkbox"/> Coronary artery bypass grafting | |
| <input type="checkbox"/> Ear or mastoid surgery | <input type="checkbox"/> Coronary artery stenting | |
| <input type="checkbox"/> Nasal or sinus surgery | <input type="checkbox"/> Lung surgery | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Removal of lymph nodes from neck | <input type="checkbox"/> Cholecystectomy (Gall Bladder) | |
| <input type="checkbox"/> Thyroid gland surgery | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Anesthesia Difficulties |
| <input type="checkbox"/> Other head or neck surgery | <input type="checkbox"/> Spine surgery | |
| <input type="checkbox"/> Orthopedic surgery | <input type="checkbox"/> Gynecological procedures | |
| <input type="checkbox"/> Other (please list) _____ | | |

CONTINUED ON BACK SIDE

Family Medical History:

Is there a family history of heart disease, stroke, cancer, hearing loss, diabetes, thyroid, etc? Please list details:

Allergy History/Drug Allergies:

Tobacco Use:

- None Previous Current
- Cigarettes Date Started: _____
- Pipe Date Stopped: _____
- Cigars Amount used daily: _____
- Chewing Tobacco
- Snuff

Beverage Consumption:

- None Previous Current
- Beer Date Started: _____
- Hard Liquor Date Stopped: _____
- Wine Amount used daily: _____
- Coffee/Tea
- Soda/Pop

Systems Review:

Please check all that apply to you:

Sleep: none loud snoring excessive daytime sleep trouble going to sleep trouble staying asleep

Constitutional: fever chills excessive weight loss or gain fatigue

Eyes: vision loss double vision tearing eyes worsening vision

Cardiovascular: palpitations racing heart chest pains cold/swollen extremities

Respiratory: wheezing dry cough productive cough night sweats shortness of breath

Gastrointestinal: increased/decreased appetite nausea vomiting abdominal pain diarrhea/constipation

Musculoskeletal: joint pain swelling stiffness muscle weakness

Integumentary: changes in skin lesion

Psychiatric: irritability depression anxiety insomnia drug or alcohol addiction (past or present)

Neurological: loss of smell or taste facial weakness or numbness memory problems headaches (how often)
 difficulty walking difficulty swallowing/speaking

Endocrine: increase in size of hands/feet heat/cold intolerance excessive thirst thyroid problems

Hematologic/Lymphatic: swollen nodes excessive bruising or bleeding

Allergic/Immunologic: allergy to medicines seasonal allergies

Additional: _____

Patient Signature

Date

