Massachusetts E.N.T. Associates
Medical History Form

Date of visit:_____
Name:_____ **D.O.B.:**_____
Address:_____
Phone: Home_____ **Work**_____ **ext.**_____ **Cell**_____
Email address:_____
Name and city of Primary Care Physician:_____
Name and city of Physician requesting consult: _____
Primary Reason for this office visit:

Major Medical Illness: (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

☐ High blood pressure	☐ Heart disease	☐ Diabetes	☐ High Cholesterol	☐ Asthma	☐ TB
☐ Emphysema/COPD	☐ GERD	☐ Stomach ulcer	☐ Stroke	☐ Arthritis	☐ Gout
☐ Fibromyalgia	☐ Kidney disease	☐ Kidney stones	☐ Hepatitis	☐ Liver disease	
☐ Atrial Fibrillation	☐ Sleep apnea	☐ Neuropathy	☐ Mitral valve prolapse	☐ Other heart valve disease	
☐ Thyroid disease	☐ Pancreatitis	☐ Depression	☐ Bipolar Disease	☐ Other Psychiatric Disease	
☐ Glaucoma	☐ Cataracts	☐ HIV	☐ Other immune disorder	☐ Bleeding disorder	

☐ Cancer (Type and treatment:_____)
☐ Other:_____

Previous Operations: (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

☐ Tonsillectomy	☐ Adenoidectomy	☐ Ear tubes	☐ Other ear surgery	☐ Septoplasty	☐ Sinus surgery
☐ Rhinoplasty	☐ Gall bladder	☐ Appendix	☐ Lung surgery	☐ AV fistula	☐ Kidney surgery
☐ Brain surgery	☐ Joint surgery	☐ Back surgery	☐ Carotid surgery	☐ Heart surgery	☐ Eye surgery
☐ Thyroid surgery	☐ G-tube	☐ Gastric bypass	☐ Colon surgery	☐ Other stomach/intestinal surgery	

☐ Other:_____

Current Medications (Including Aspirin/Herbal medicines/Over the counter medications):

Allergies to medications, foods and environmental causes:

Pharmacy name and address:

Family History: (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

☐ High blood pressure	☐ Heart disease	☐ Diabetes	☐ High Cholesterol	☐ Asthma	☐ TB
☐ Emphysema/COPD	☐ GERD	☐ Stomach ulcer	☐ Stroke	☐ Arthritis	☐ Gout
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☐ Thyroid disease	☐ Pancreatitis	☐ Depression	☐ Bipolar Disease	☐ Other Psychiatric Disease	
☐ Glaucoma	☐ Cataracts	☐ HIV	☐ Other immune disorder	☐ Bleeding disorder	

☐ Cancer (Type and treatment:_____)
☐ Other:_____

Social History: Have you ever smoked? ☐ Yes ☐ No **How many years?**_____
How much? **When did you quit?**_____
Alcoholic beverages per day: _____
Recreational drugs: Prior use? ☐ Yes ☐ No **Current use?** ☐ Yes ☐ No
Occupation:_____
Hobbies:_____ **Do you use your voice professionally?** ☐ Yes ☐ No

Patient Name:_____ **Date of visit:**_____

Review of Systems: Do YOU have: (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

☐ Loss of Hearing
☐ Sense of ear blockage
☐ Facial weakness
☐ Ringing in ears/tinnitus
☐ Ear pain
☐ Previous ear surgery
☐ Dizziness/vertigo
☐ Ear drainage
☐ Exposure to loud noise
☐ Hearing aids
☐ Family history of hearing loss

☐ Nose bleeds
☐ Loss of sense of smell
☐ Sinus problems
☐ Nasal congestion/obstruction
☐ Nasal polyps
☐ Facial pain
☐ Nasal discharge
☐ Concern about nasal appearance
☐ Post nasal drip

☐ Recurrent sore throats
☐ Neck swelling/mass
☐ Hoarseness
☐ Neck infections
☐ Trouble/pain with swallowing
☐ Thyroid disease/nodule/goiter

☐ Chest pain/pressure
☐ Shortness of breath
☐ Cough
☐ Wheezing

☐ Abdominal pain
☐ Nausea/vomiting
☐ Diarrhea
☐ Problems with urination
☐ Constipation
☐ Heartburn/indigestion

☐ Seizures
☐ History of migraines
☐ Numbness
☐ Vision problems
☐ Paralysis
☐ Headaches

☐ Anemia
☐ Easy bleeding or bruising
☐ Fevers
☐ Unexplained weight loss

☐ Joint pain
☐ Muscle weakness
☐ Osteoporosis

☐ Skin disorders/diseases

☐ Second hand smoke exposure

FEMALE PATIENTS: Are you pregnant? ☐ No ☐ Yes (Number of weeks:)

Tests and studies: Have you had any tests or studies relevant to today's visit? If yes, please note these below:

Test **Hospital where test was performed**

☐ XRAY/CT/MRI _____ → Part of body (e.g. sinuses, adenoids, ears, neck, etc.):

_____

☐ Neck/Thyroid Ultrasound _____

☐ Thyroid blood tests _____

☐ Swallowing study _____

☐ Hearing test(s) _____

☐ Allergy tests _____

☐ Biopsies of the ear, nose, throat, face, or neck _____

Please list any other pertinent medical information that may be helpful to the doctor, as well as any other concerns you would like addressed during your office visit: