Ear, Nose & Throat Associates of North Central Wisconsin, S.C.

HISTORY SHEET

Today's Date

Patient's Name ______________________________ Birthdate __________ Age _____
Last First Inital

Home Address ______________________________ City, State, Zip ______________________________

Sex: M F Marital Status: S M W D If child, name of parent or guardian ______________________________

Phone: ______________ ______________ ______________ Employer: ______________
Home Cell Work

Social Security No. ______________________________ E-MAIL: ______________________________

Family Doctor: ______________________________ Doctor's City: ______________________________

Who told you about our clinic: (circle one) Your Family/Friend, Your Doctor, Other ______________________________

Name of Doctor requesting your appointment today: ______________________________

Reason for your appointment today: ______________________________

PAST MEDICAL HISTORY

CURRENT MEDICATIONS (Including over-the-counter drugs, aspirin & nose sprays)

DRUG NAME	REASON	DOSAGE

MAJOR ILLNESSES

(Please list any serious illnesses, injuries, and non-surgical hospitalizations you have or have had, eg. diabetes, high blood pressure, heart disease, stroke, AIDS, cancer, etc.)

DISEASE	YEAR OF ONSET

OPERATIONS (Please list all surgeries and year of surgery)

SURGERY	YEAR

(OVER)

DRUG REACTION/DRUG ALLERGIES

Drug	Type of Reaction

FAMILY HISTORY

Reactions to anesthesia	Bleeding tendency
Other	

HABITS

TYPE	CURRENT USE	AGE STARTED
TOBACCO ❑ Cigarettes ❑ Cigars ❑ Pipes ❑ Chew		
ALCOHOL ❑ Beer ❑ Wine ❑ Liquor	Drinks/week	

REVIEW OF SYSTEMS

*Please check if you have problems in any of the following areas:

GENERAL	Yes	No
Weight Loss?	_____	_____
Fever?	_____	_____
EYES:		
Double Vision?	_____	_____
Loss of Vision?	_____	_____
Glaucoma?	_____	_____
RESPIRATORY:		
Asthma?	_____	_____
Lung Disease?	_____	_____
Wheezing?	_____	_____
Shortness of Breath?	_____	_____
Second Hand Smoke Exposure?	_____	_____
CARDIAC:		
History of Heart Attack?	_____	_____
Angina or Chest Pain?	_____	_____
GASTROINTESTINAL:		
Heartburn?	_____	_____
Taste Stomach Acids?	_____	_____
Peptic Ulcer Disease?	_____	_____

GENITOURINARY:	Yes	No
Urinary Tract Infection?	_____	_____
Trouble with Urine Stream?	_____	_____
HEMATOLOGICAL:		
Post Surgical Bleeding?	_____	_____
Bruise Easily?	_____	_____
AIDS or HIV Exposure?	_____	_____
EARS:		
Hearing Loss?	_____	_____
Noise Exposure?	_____	_____
OTHER:		
Mental Illness?	_____	_____
Depression?	_____	_____
Thyroid Disease?	_____	_____
Tuberculosis (TB)?	_____	_____
Snoring?	_____	_____
Lymph Node Swelling?	_____	_____

____

Signature of Patient (Parent or Guardian for Minor) Date