EASTERN OKLAHOMA
EAR, NOSE & THROAT, Inc.

PATIENT HISTORY

Name: ______________________ Date of Birth: ______________

Primary Care Physician: ______________ Referring Physician: ______________

Pharmacy: ______________________

Reason for today's visit: ______________________

Date of onset/length of symptoms: ______________________

Are any of your family members seen by any of our doctors? If so, please provide the family member's name(s).

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Past medical history: Please circle all that apply.

Allergies	**Asthma**	**Bleeding disorder**	**Cancer, Type:**
Diabetes	**Reflux**	**Heart disease**	**Heart attack**
Hepatitis	**Hypertension**	**Kidney problems**	**Lung disease**
Seizures	**Sleep apnea**	**Stroke**	**Thyroid disease**

Other: ______________________

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Surgical history: ______________________

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Date of last flu vaccine: ______________ Date of last pneumonia vaccine: ______________

Please list all current medications: ☐ No current medications

Name	Dose	How often taken

Are you allergic to any medications? ☐ No ☐ Yes, if yes, please list: ______________

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Social history: Please check all that apply

Tobacco use: Smoke cigarettes: ☐ Never ☐ No ☐ Yes

Quit date: ______________________ How many years did you smoke? ______________________

Current smoker: Packs/day: ______________________ # of years: ______________________

Smokeless tobacco: ☐ No ☐ Yes E-cigarette use: ☐ No ☐ Yes

Exposure to secondary smoke: ☐ No ☐ Yes

Alcohol use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Daycare attendance: ☐ No ☐ Yes Grade in school: ______________________

Family history: Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mom/Dad	Brother/Sister	Other
Allergies			
Anesthesia problems			
Bleeding disorder			
Cancer: Type			
Diabetes			
Hearing loss			
Heart disease			

Review of systems: Please mark the box of any persistent symptoms you have had in the last few months.

General
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue
- ☐ Fever/chills

Respiratory
- ☐ Asthma
- ☐ Coughing/wheezing
- ☐ Shortness of breath

Musculoskeletal
- ☐ Arthritis
- ☐ Back pain
- ☐ Muscle weakness

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Swollen nodes/glands
- ☐ Easy bruising/bleeding

Skin
- ☐ Dry skin
- ☐ Skin discoloration
- ☐ Rash/hives

Cardiac
- ☐ Chest pain
- ☐ Fast or irregular heartbeat
- ☐ Hypertension

Neurological
- ☐ Headaches
- ☐ Fainting
- ☐ Seizures

Eyes
- ☐ Itchy eyes
- ☐ Watery eyes
- ☐ Pain around eyes

GI
- ☐ Heartburn
- ☐ Reflux
- ☐ Swallowing difficulty

Endocrine
- ☐ Heat or cold sensitivity
- ☐ Hot flashes
- ☐ Thyroid problems

Patient signature ______________________ Date ______________________

Physician comments: