SCOTCH INSTITUTE
ENT | Hearing | Allergy | Sleep
a division of ENT & Allergy Associates of Florida

PATIENT MEDICAL HISTORY

Date: _____

Patient Name: _____ **Date of Birth:** _____

Primary reason for today's visit: _____

Allergies (*write "no" if none):*	Current Medications *(write "no" if none):*	Age:
		Height:
		Weight:

Check all that apply:

Other Medical Conditions
D High Blood Pressure
D Bleeding Disorder
D Glaucoma
D Diabetes
D Stroke
D Thyroid Disease
D Sleep Apnea
D Asthma
D Cancer (of_____)
D Poor Circulation
D Heart Disease
D Other: _____

Check all that apply:

Past Surgeries
D Tonsillectomy
D Adenoidectomy
D Thyroidectomy
D Ear Surgery
D Sinus Surgery
D Nasal Septoplasty
D Carotid Artery Surgery
D Ear Tubes
D Pacemaker
D Heart Bypass / Valve
D Other: _____

Check all that apply:

Family History of Illness
D High Blood Pressure
D Bleeding Disorder
D Glaucoma
D Diabetes
D Stroke
D Thyroid Disease
D Hearing Loss
D Vertigo
D Cancer (of_____)
D Poor Circulation
D Heart Disease
D Other: _____

How often do you use Alcohol?
D Never
D Occasionally
D Daily: How Much ?

*Did you **ever** chew Tobacco?*
D Never did
D Yes
D Quit: When?

*Did you **ever** Smoke?*
D Never did
D Yes: packs per day for years
D Quit: When?

Review of Systems: Do you have any of these symptoms? Please check *yes* or *no* to each item…

		Yes	No
General	fever	D	D
	weight loss	D	D
	night sweats/chills	D	D
Ear, Nose & Throat	ear pain or itch	D	D
	dizziness	D	D
	nasal congestion	D	D
	ear drainage	D	D
	loss of smell	D	D
	throat pain	D	D
	hearing loss	D	D
	sinus pressure	D	D
	hoarseness	D	D
	ringing in ears	D	D
	nasal drainage	D	D
	snoring	D	D
Cardiac	chest pain when walking	D	D
	swollen ankles	D	D
	blackouts	D	D
Lung	cough	D	D
	shortness of breath	D	D
	blood in sputum	D	D
Endocrine	excessive sleepiness	D	D
	excessive thirst	D	D
	in ability to sleep	D	D
Heme/L	swollen glands	D	D
	bleeding problems	D	D
	blood transfusions	D	D
Allergy	sneezing	D	D
	post-nasal drip	D	D
	history of allergy shots	D	D
Eyes	dry eyes	D	D
	double vision	D	D
	excessive tears	D	D
Muscle	neck pain	D	D
	joint pains	D	D
	pain in jaw with chewing	D	D
Neuro	numbness	D	D
	paralysis/weakness	D	D
	headache	D	D
Psychiatric	depression	D	D
	anxiety	D	D
	memory loss	D	D
Skin	rash	D	D
	ulcers/growths	D	D
	discoloration	D	D
GI	heartburn	D	D
	difficulty swallowing	D	D
	nausea	D	D
GU	difficulty urinating	D	D
	blood in urine	D	D
	might you be pregnant now	D	D

Patient (or Guardian) Signature: _____ Date: _____

Physician Signature: _____ Date: _____