Ear Nose & Throat CENTER

Patient History

Name ______________________

Date of birth ______________________

Reason for today's visit ______________________

____

Who is your primary care doctor?

Name ______________________

Address ______________________

____

Phone ______________________

How did you hear about our practice?

- ○ Family or friends
- ○ Physician Dr. ______________________
- ○ Lutheran General Hospital
- ○ PPO List
- ○ Internet

Do you or any of your family members have any of the following?

	Myself	Relative	Neither
Bleeding Tendency	☐	☐	☐
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
Heart Disease	☐	☐	☐
Asthma/Emphysema	☐	☐	☐
Skin problems	☐	☐	☐
Cancer	☐	☐	☐
Hepatitis/Liver Disease	☐	☐	☐
Thyroid Disease	☐	☐	☐
Kidney Disease	☐	☐	☐
Seizures or Stroke	☐	☐	☐
Infectious Disease	☐	☐	☐
Other ______________________			
Ringing/Buzzing in Ears	☐	☐	☐
Hearing Loss	☐	☐	☐
Allergies/Hayfever	☐	☐	☐
Previous Allergy Testing	☐	☐	☐

When was your last hearing test? ______________________

Please complete: *Height:* ________ *Weight:* ________

Please list medications you take: ☐ ***None***

____

____

____

____

____

____

____

____

Please list any allergies to medications: ☐ ***None***

____

____

Previous hospitalizations and surgery: ☐ ***None***

Reason	Date	Hospital

Have you met Dr.______________________**before? If yes, explain**______________________

Do you smoke? __________ **How Much?** __________ **Do you drink?** __________ **How much?** __________

I read and understood the notice of privacy practices regarding my care.

Signature ______________________ Date ______________

For office use: Reviewed by: Date Reviewed by: Date

______________________ ______________________

______________________ ______________________

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