COLORADO WEST OTOLARYNGOLOGISTS, P.C.

Confidential Record: Information contained herein will not be released except when you have authorized us to do so.

Patient Medical History Form **Referring Doctor** ______________________________ Date ______________________

Name ____ DOB ______________________________

Reason For Visit ____

When did problem first appear? ____________________________ Please list name and approximate date of previous treatment for this problem from other practitioners ____

____

Ear Nose and Throat Questions Please Check all that apply to **You**

- ❑ Sore spot or abnormal bump in mouth or throat
- ❑ Dentures
- ❑ Difficulty Swallowing
- ❑ Sensation of a lump in your throat
- ❑ Hoarseness
- ❑ Pain on swallowing
- ❑ Nosebleeds
- ❑ Obstructed breathing through nose
- ❑ Draining Sinus
- ❑ Headaches
- ❑ Mouth or Throat bleeding
- ❑ Recurrent Sinusitis
- ❑ Hay Fever
- ❑ Hearing Loss
- ❑ Ringing in Ears
- ❑ Ear Pain
- ❑ Ear Drainage
- ❑ Dizziness
- ❑ Eye Pain
- ❑ Blind Spots
- ❑ Glaucoma
- ❑ Double Vision
- ❑ Sudden loss of vision which later returns to normal
- ❑ Wear glasses
- ❑ Wear contacts

Comments: ____

General Health Questions Please Check all that apply to **You**

- ❑ Wheezing
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Low blood pressure
- ❑ Chest pains
- ❑ Irregular heart beat/Palpitations
- ❑ Urinary infections
- ❑ Heart burn (requiring frequent antacids)
- ❑ Colitis
- ❑ Chronic diarrhea
- ❑ Jaundice
- ❑ Pancreatitis
- ❑ Hiatal hernia
- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Trouble opening mouth
- ❑ Shortness of breath
- ❑ Constant cough
- ❑ Limited joint motion
- ❑ Muscle weakness
- ❑ Have you ever had any Neurological problem?
- ❑ Head injury
- ❑ Numbness/Weakness
- ❑ Depression
- ❑ Anxiety Disorder
- ❑ Other Mental Problems
- ❑ Thyroid disease
- ❑ Diabetes
- ❑ Anemia
- ❑ Sickle cell disease/trait
- ❑ Easily bruised

Comments: ____

Drug Allergies and Reactions ____

Children

Immunizations current & up to date? _____ Yes _____ No History of chicken pox? _____ Yes _____ No
Chicken pox vaccine? _____ Yes _____ No

Family History Has a blood relative had:

- ❑ Reaction to anesthesia
- ❑ Bleeding problems
- ❑ Heart disease
- ❑ Diabetes
- ❑ Cancer

Medical Illnesses Please Check all that apply to **You**

- ❑ Cancer - what part of the body? ______________________________
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Emphysema
- ❑ Diabetes
- ❑ Heart troubles
  - ❑ Heart Attack
  - ❑ Rheumatic Fever
  - ❑ Congestive Heart Failure
  - ❑ Atrial Fibrillation
- ❑ High Blood pressure
- ❑ High cholesterol/triglycerides
- ❑ Stroke
- ❑ Epilepsy/Seizures
- ❑ Ulcers
- ❑ Thyroid disorder _________
  - ❑ Hyperthyroid
  - ❑ Hypothyroid
- ❑ Bleeding problems
- ❑ Kidney Stones
- ❑ Hepatitis – Type _________
  - ❑ Active
  - ❑ Inactive
- ❑ HIV/AIDS

Surgeries/Hospitalizations:
Please list the name and approximate date of **ALL** previous surgical procedures and serious hospitalizations.

Name of Operation	Date	Name of Operation	Date

Have **You** ever had a serious reaction to anesthesia? ☐ Yes ☐ No If yes, describe ______________________________
Are You Pregnant? ☐ Yes ☐ No ☐ N/A
Have **You** ever had a blood transfusion? ☐ Yes ☐ No When? ______________________________

Social History

Marital Status ☐ S ☐ M ☐ D ☐ W Do you have children ☐ Yes ☐ No (Ages)______________________________

Profession______________________________

Place an "X" in proper Column

	Yes	No		
Do you or have you chewed tobacco?			How long?	Date quit -
Do you or have you ever smoked cigarettes ___ or marijuana ___?			How long? How many packs a day?	Date quit -
Do you drink alcohol?			How much per week?	
Do you or have you ever used cocaine or IV drugs?			How often?	

Please list the medications you are now taking (or attach list if extensive)

Name	Strength(mg)	Times per day	Name	Strength(mg)	Times per day

Please list your pharmacy of choice for prescriptions.______________________________