HIGHLAND CLINIC

FAX FORM TO 4451

ENT

DATE:_____ PATIENT HISTORY FORM PCP / REFERRING MD

MD you are seeing today _____ _____

Name:_____ DOB:_____ Age:_____

Reason for Visit:_____ Doctor_____

Review of Systems: ***Do you have?***

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight change
- ☐ Night Sweats
- ☐ Visual loss
- ☐ Itchy Eyes
- ☐ Tearing
- ☐ Blurred vision
- ☐ Double Vision
- ☐ Vertigo
- ☐ Dizziness
- ☐ Ringing Noise
- ☐ Hearing Loss
- ☐ Ear Ache
- ☐ Ear Drainage
- ☐ Nasal Discharge
- ☐ Post Nasal Drip
- ☐ Stuffy Nose
- ☐ Nose Bleeds
- ☐ Sneezing
- ☐ Dental Problems
- ☐ Tonsillitis
- ☐ Mouth Sores
- ☐ Hoarseness
- ☐ Voice Changes
- ☐ Problems Swallowing
- ☐ Throat Pain
- ☐ Neck Pain
- ☐ Thyroid Nodule
- ☐ Swollen Glands
- ☐ Skin Growth/Sores
- ☐ Rash
- ☐ Itching
- ☐ Skin/Hair/Nail Changes
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swelling Hands/Feet
- ☐ Wheezing
- ☐ Coughing up Blood
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Headache
- ☐ Migraines
- ☐ Fainting
- ☐ Numbness
- ☐ Weakness
- ☐ Slurred Speech
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Cold/Heat Intolerant
- ☐ Easy Bruising/Bleeding
- ☐ Transfusion
- ☐ Immunocompromised
- ☐ Anemia
- ☐ Blood Clots
- ☐ Snoring
- ☐ Apnea
- ☐ Insomnia
- ☐ daytime tiredness
- ☐ Excessive Thirst/Urination

Past Medical History: *Have you had?*

- ☐ None
- ☐ Cancer – Specify_____
- ☐ Gerd / Reflux
- ☐ COPD / Emphysema
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Depression/Anxiety
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Mitral Valve Prolapse
- ☐ High Cholesterol
- ☐ Thyroid Disease
- ☐ Heart Attack
- ☐ Allergy / Hayfever

Other_____

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Past Surgical History:

Have you had?	*Year*
☐ Thyroid	____
☐ Appendectomy	____
☐ Hysterectomy	____
☐ Gallbladder	____
☐ Tonsillectomy	____
☐ Wisdom Teeth	____
☐ Other_____	
☐ None	

Family History: *Please indicate family member*

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Bleeding Problems
- ☐ Cancer – Specify _____
- ☐ Other _____
- ☐ Rheumatologic Disease
- ☐ None

Social History: Marital Status _____

Occupation:_____

- ☐ None
- ☐ Tobacco Use ☐ current ☐ never ____Pks/Day
- ☐ Former Tobacco Use Yes Year Quit: _____
- ☐ 2nd Hand Smoke Yes No
- ☐ Alcohol Use Yes No
- ☐ Drug Use Yes No

Drug Allergies-list reaction for each allergy _____

Medications: *Drug Name Dose/Strength/Directions* Do you take blood thinners? ☐ Yes ☐ No

All patients please complete medication list. Additional meds can be listed on the back of this sheet.

_____ _____

_____ _____

_____ _____

_____ _____