

ENT Surgical Health History Form

First Name: _____ Middle: _____ Last Name: _____

SSN: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Gender: Male Female Other

Address: _____ City: _____ State: _____ Zip: _____

Home Phone (____) _____ - _____ Work Phone: (____) _____ - _____ Primary Physician: _____

Occupation: _____ Marital Status: _____ Number of Children: _____

REVIEW OF SYMPTOMS - CHECK ONLY THE ONES YOU NOW HAVE OR HAVE HAD RECENTLY.

<p>GENERAL</p> <input type="checkbox"/> WEAKNESS <input type="checkbox"/> FATIGUE <input type="checkbox"/> FEVER <input type="checkbox"/> CHILLS <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> FAINTING <input type="checkbox"/> NONE	<p>SKIN</p> <input type="checkbox"/> SKIN COLOR CHANGES <input type="checkbox"/> SKIN RASHES <input type="checkbox"/> ITCHY SKIN <input type="checkbox"/> SKIN SORES <input type="checkbox"/> NONE	<p>HEAD</p> <input type="checkbox"/> HEADACHES <input type="checkbox"/> HEAD INJURIES <input type="checkbox"/> HEAD LESIONS <input type="checkbox"/> HEAD/FACIAL LESIONS <input type="checkbox"/> NONE	<p>EYES</p> <input type="checkbox"/> BLURRED VISION <input type="checkbox"/> EYE REDNESS <input type="checkbox"/> ITCHY EYES <input type="checkbox"/> BURNING EYES <input type="checkbox"/> EYE SWELLING <input type="checkbox"/> EYE PAIN <input type="checkbox"/> DRY EYES <input type="checkbox"/> TEARING <input type="checkbox"/> NONE	<p>EARS</p> <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> RINGING <input type="checkbox"/> EAR DISCHARGE <input type="checkbox"/> EARACHE <input type="checkbox"/> ITCHY EARS <input type="checkbox"/> LOSS OF BALANCE <input type="checkbox"/> DIZZINESS <input type="checkbox"/> ROOM SPINS <input type="checkbox"/> EAR BLOCKAGE/OBSTRUCTION <input type="checkbox"/> EAR INFECTIONS <input type="checkbox"/> EAR LESIONS/SORES/DEFORMITY <input type="checkbox"/> NONE
<p>NOSE</p> <input type="checkbox"/> LOSS OF SMELL <input type="checkbox"/> NOSE BLEEDS <input type="checkbox"/> NASAL PAIN <input type="checkbox"/> NASAL DISCHARGE <input type="checkbox"/> NASAL OBSTRUCTION <input type="checkbox"/> NASAL CONGESTION <input type="checkbox"/> SNORING <input type="checkbox"/> POST NASAL DRIP <input type="checkbox"/> DEVIATED SEPTUM <input type="checkbox"/> RUNNY NOSE <input type="checkbox"/> SINUS CONGESTION <input type="checkbox"/> NASAL SORES/LESIONS <input type="checkbox"/> NONE	<p>MOUTH</p> <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/> ORAL SORES <input type="checkbox"/> DENTAL PROBLEMS <input type="checkbox"/> MOUTH/JAW PAIN <input type="checkbox"/> BAD BREATH <input type="checkbox"/> LOSS OF TASTE <input type="checkbox"/> DRY MOUTH <input type="checkbox"/> ORAL ULCERS <input type="checkbox"/> ORAL BLISTERS <input type="checkbox"/> BAD TASTE <input type="checkbox"/> NONE	<p>THROAT</p> <input type="checkbox"/> SORE THROAT <input type="checkbox"/> BAD TONSILS/TONSILLITIS <input type="checkbox"/> HOARSENESS <input type="checkbox"/> HARD TO SWALLOW <input type="checkbox"/> RECURRENT INFECTIONS <input type="checkbox"/> ORAL WHITE SPOTS <input type="checkbox"/> NONE	<p>NECK</p> <input type="checkbox"/> NECK ENLARGEMENT <input type="checkbox"/> NECK STIFFNESS <input type="checkbox"/> NECK SORENESS/PAIN <input type="checkbox"/> NECK LUMPS <input type="checkbox"/> NECK MASSES <input type="checkbox"/> NONE	<p>LUNGS</p> <input type="checkbox"/> COUGH <input type="checkbox"/> PHLEGM <input type="checkbox"/> COUGHED BLOOD <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> WHEEZING <input type="checkbox"/> PAIN IN LUNGS <input type="checkbox"/> CHEST CONGESTION <input type="checkbox"/> INHALANT EXPOSURE <input type="checkbox"/> NONE
<p>HEART</p> <input type="checkbox"/> MURMUR <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> RAPID HEARTBEAT <input type="checkbox"/> SWOLLEN EXTREMITIES <input type="checkbox"/> COLD EXTREMITIES <input type="checkbox"/> TIGHTNESS/PRESSURE <input type="checkbox"/> CHEST PAINS <input type="checkbox"/> VARICOSE VEINS <input type="checkbox"/> BLOOD CLOTS <input type="checkbox"/> BLUE EXTREMITIES <input type="checkbox"/> NONE	<p>GASTROINTESTINAL</p> <input type="checkbox"/> ABDOMINAL PAIN <input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING <input type="checkbox"/> ABDOMINAL BLOATEDNESS <input type="checkbox"/> BELCHING <input type="checkbox"/> HEARTBURN <input type="checkbox"/> INDIGESTION <input type="checkbox"/> NONE	<p>NEUROLOGICAL</p> <input type="checkbox"/> SEIZURES <input type="checkbox"/> VERTIGO <input type="checkbox"/> LOSS OF FACIAL EXPRESSIONS <input type="checkbox"/> WEAK GRIP <input type="checkbox"/> PARALYSIS <input type="checkbox"/> SLURRED SPEECH <input type="checkbox"/> TINGLING/BURNING/NUMBING <input type="checkbox"/> DISORIENTATION <input type="checkbox"/> NONE	<p>PSYCHIATRIC</p> <input type="checkbox"/> HYPERVENTILATION <input type="checkbox"/> ALCOHOL ABUSE <input type="checkbox"/> DRUG USE <input type="checkbox"/> DRUG ABUSE/ADDICTION <input type="checkbox"/> NONE	<p>ENDOCRINE</p> <input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> WEIGHT GAIN <input type="checkbox"/> HOARSENESS/VOICE CHANGES <input type="checkbox"/> HYPOLYCEMIA/LOW BLOOD SUGAR <input type="checkbox"/> DIABETES/ HIGH BLOOD SUGAR <input type="checkbox"/> NONE

MEDICATIONS: List all medications you are currently taking. Include ALL medications even the over the counter ones.

Drug Name (Generic/Brand)	Dosage	Frequency	Status
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd
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<p>NOSE</p> <input type="checkbox"/> LOSS OF SMELL <input type="checkbox"/> NOSE BLEEDS <input type="checkbox"/> NASAL PAIN <input type="checkbox"/> NASAL DISCHARGE <input type="checkbox"/> NASAL OBSTRUCTION <input type="checkbox"/> NASAL CONGESTION <input type="checkbox"/> SNORING <input type="checkbox"/> POST NASAL DRIP <input type="checkbox"/> DEVIATED SEPTUM <input type="checkbox"/> RUNNY NOSE <input type="checkbox"/> SINUS CONGESTION <input type="checkbox"/> NASAL SORES/LESIONS <input type="checkbox"/> NONE	<p>MOUTH</p> <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/> ORAL SORES <input type="checkbox"/> DENTAL PROBLEMS <input type="checkbox"/> MOUTH/JAW PAIN <input type="checkbox"/> BAD BREATH <input type="checkbox"/> LOSS OF TASTE <input type="checkbox"/> DRY MOUTH <input type="checkbox"/> ORAL ULCERS <input type="checkbox"/> ORAL BLISTERS <input type="checkbox"/> BAD TASTE <input type="checkbox"/> NONE	<p>THROAT</p> <input type="checkbox"/> SORE THROAT <input type="checkbox"/> BAD TONSILS/TONSILLITIS <input type="checkbox"/> HOARSENESS <input type="checkbox"/> HARD TO SWALLOW <input type="checkbox"/> RECURRENT INFECTIONS <input type="checkbox"/> ORAL WHITE SPOTS <input type="checkbox"/> NONE	<p>NECK</p> <input type="checkbox"/> NECK ENLARGEMENT <input type="checkbox"/> NECK STIFFNESS <input type="checkbox"/> NECK SORENESS/PAIN <input type="checkbox"/> NECK LUMPS <input type="checkbox"/> NECK MASSES <input type="checkbox"/> NONE	<p>LUNGS</p> <input type="checkbox"/> COUGH <input type="checkbox"/> PHEGEM <input type="checkbox"/> COUGHED BLOOD <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> WHEEZING <input type="checkbox"/> PAIN IN LUNGS <input type="checkbox"/> CHEST CONGESTION <input type="checkbox"/> INHALANT EXPOSURE <input type="checkbox"/> NONE
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