PRESCOTT ENT & ALLERGY

EAR, NOSE & THROAT · HEAD & NECK SURGERY · ALLERGY · AUDIOLOGY

MARK D. STRASSER, M.D. • DEREK K. HEWITT, M.D. • DAVID A. HOLMES, AU.D.

MEDICAL HISTORY

Patient name: _____ DOB: _____ Insurance: _____

Last seen in our office: _____ Family doctor: _____

Referring physician: _____

Height: _____ft _____in Weight: _____lbs

Do you currently have any of the following symptoms?

General	No	Yes
Fevers	☐	☐
Fatigue	☐	☐
Night sweats	☐	☐
Weight gain/loss	☐	☐
Ears		
Itching	☐	☐
Pain	☐	☐
Fullness/pressure	☐	☐
Hearing loss	☐	☐
Ringing	☐	☐
Nose		
Congestion	☐	☐
Post nasal drip	☐	☐
Facial pain	☐	☐
Runny nose	☐	☐
Loss of smell	☐	☐

Throat	No	Yes
Difficulty swallowing	☐	☐
Heartburn	☐	☐
Throat pain	☐	☐
Hoarseness	☐	☐
Skin		
Rash	☐	☐
Itching	☐	☐
Excess scarring	☐	☐
Bleeding problems	☐	☐
Neurologic		
Severe headaches	☐	☐
Numbness/tingling	☐	☐
Transient paralysis	☐	☐
Poor memory	☐	☐

Vestibular	No	Yes
Light headed	☐	☐
Spinning sensation	☐	☐
Falling	☐	☐
Joint pain	☐	☐
Eyes		
Itching	☐	☐
Blurring	☐	☐
Double vision	☐	☐
Neck		
Lump/mass	☐	☐
Respiratory		
Cough	☐	☐
Shortness of breath	☐	☐
Chest pain	☐	☐

List all medicines you are currently taking, with their dosages.

_____ _____

_____ _____

_____ _____

Do you have any medical allergies? ☐ Yes ☐ No

If yes, please list medicine and your reaction.

_____ _____

_____ _____

_____ _____

_____ _____

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Do you have or have you had any of the following medical conditions?

	Current	Past
Adverse anesthetic effects	☐	☐
Arthritis	☐	☐
Heart failure	☐	☐
Diabetes	☐	☐
Genetic bleeding hx	☐	☐
High blood pressure	☐	☐
Pain	☐	☐
Insomnia	☐	☐
Osteoporosis	☐	☐

	Current	Past
Allergic rhinitis	☐	☐
Anemia	☐	☐
Asthma	☐	☐
Clotting disorder	☐	☐
Emphysema	☐	☐
Heart attack	☐	☐
High cholesterol	☐	☐
Kidney failure	☐	☐
Stroke	☐	☐

	Current	Past
Anxiety	☐	☐
Atrial fibrillation	☐	☐
Depression	☐	☐
Gout	☐	☐
Heartburn	☐	☐
Hypothyroid	☐	☐
Migraine	☐	☐
Peripheral vascular disease	☐	☐

Do you have any other medical conditions not listed above? Please list them.

_____ _____

_____ _____

_____ _____

Please list all surgeries that you have undergone.

_____ _____

_____ _____

_____ _____

Do you have a family history of any of the following? Please Check.

☐ Adverse anesthetic effects
☐ Thyroid cancer
☐ Circulatory disorder
☐ Asthma
☐ Diabetes
☐ Stroke
☐ Allergic rhinitis
☐ Clotting disorder
☐ High blood pressure
☐ Heart attack
☐ Emphysema
☐ Hearing loss
☐ Coronary artery disease
☐ Depression
☐ Migraine
☐ Osteoporosis
☐ High cholesterol
☐ Anxiety

Add any other family history problems below.

_____ _____

_____ _____

Do you smoke? ☐ Yes ☐ No If yes: Packs per day: _____ Number of years: _____

Former smoker ☐ Yes ☐ No When did you stop smoking? _____

Never smoked ☐ Yes ☐ No

Chew tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ No ☐ Infrequently ☐ Frequently

Do you use any recreational or other type of drugs? ☐ Yes ☐ No If yes, what type? _____

If a child, is the child up-to-date with his/her immunizations? ☐ Yes ☐ No