GATEWAY ENT
ear, nose and throat specialists

# PATIENT MEDICAL HISTORY FORM

**Patient Name:** ________________ **Age:** ______ **Date of Birth:** ________ **Sex:** ______

**Primary Physician:** ________________ **Pharmacy**: ________________
(Include Pharmacy Name, Phone Number, and Zip code)

## NATURE OF VISIT:

~ **Chief Complaint** (Reason for today's visit): ________________

~ **History of Present Illness** (Describe the signs/symptoms that you have, when they started, and how they have changed):

- **Location** (Where is the problem?): ________________
- **Quality** (Dull, Throbbing, Sharp): ________________
- **Severity** (Mild, Moderate, Severe): ________________
- **Context** (Better, Worse, Chronic): ________________
- **Timing** (Daily, With Activity, At Night): ________________
- **Duration** (How long does it last?): ________________
- **Associated Signs & Symptoms**: ________________

**Do you currently take ANY medications:** ☐ Yes ☐ No  If Yes, list **Name of Mediction**, **Dosage** and **Frequency**:

| Name of Medication | Dosage | Frequency | Name of Medication | Dosage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Drug Allergies:** ☐ Yes ☐ No  If Yes, list **Name of Drug** and **Reaction**:

| Name of Drug | Reaction |
|---|---|
| | |
| | |
| | |
| | |

**Latex Allergy:** ☐ Yes ☐ No

## PAST MEDICAL HISTORY (Have you been diagnosed with any of the following? Please check all that apply.)

- ☐ Allergies
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Cancer; Type: ________________
- ☐ Glaucoma/Cataracts
- ☐ Cerebral Palsy
- ☐ COPD/Emphysema
- ☐ Hearing Loss
- ☐ Diabetes
- ☐ GERD/Reflux
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension/High BP
- ☐ Mental Disorder
- ☐ Migraines
- ☐ Pacemaker
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tinnitus
- ☐ Vitamin D Deficiency
- ☐ Other: ________________

## PAST SURGICAL HISTORY

**ENT Surgery(ies)**

- ☐ Adenoidectomy
- ☐ Ear Surgery
- ☐ Ear Tubes
- ☐ Other: ________________
- ☐ Nasal/Sinus
- ☐ Thyroid
- ☐ Tonsillectomy

**Other Surgery(ies)**

________________
________________
________________

## FAMILY HISTORY (Do any family members have any of the medical problems listed below?)

| | Relationship | | Relationship |
|---|---|---|---|
| ☐ Asthma | ____________ | ☐ Heart Disease | ____________ |
| ☐ Bleeding Disorders | ____________ | ☐ High Blood Pressure | ____________ |
| ☐ Cancer | ____________ | ☐ Kidney Disease | ____________ |
| ☐ Diabetes | ____________ | ☐ Liver Disease | ____________ |
| ☐ Hearing Loss | ____________ | ☐ Stroke | ____________ |

## SOCIAL HISTORY

**FLU Shot (Date):** ______________ **Pneumonia Shot (Date):** ______________

**Do you use Tobacco?** (cigarettes,vape,cigars,pipe,snuff/chew) ☐ **Yes** ☐ **No**

- If **Yes** please indicate **TYPE** and **Frequency**: ______________________________

If you quit using tobacco please list the year you quit: __________ How many years did you use tobacco? ________

**Do you use alcohol?** ☐ **Yes** ☐ **No** If yes please indicate frequency: ______________________________

If you quit using alcohol please list the year you quit: __________ How many years did you drink? __________

## CURRENT SYMPTOMS (Check any of the following that apply to you today)

**Constitutional**
- ☐ Fever
- ☐ Weight Gain
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Daytime Drowsiness

**Eyes**
- ☐ Vision Change
- ☐ Eye Drainage
- ☐ Eye Pressure

**ENT**
- ☐ Hearing Loss
- ☐ Dizziness
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Nose Bleed
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Loss of Smell
- ☐ Tinnitus
- ☐ Nasal Discharge

**Cardiovascular**
- ☐ Chest Pain
- ☐ Heart Palpitations

**Respiratory**
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Cough

**Gastrointestinal**
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Heart Burn
- ☐ Indigestion
- ☐ Reflux

**Musculoskeletal**
- ☐ Joint Pain
- ☐ Facial Pain

**Neurologic**
- ☐ Numbness
- ☐ Headache
- ☐ Migraines

**Psychiatric**
- ☐ Confusion
- ☐ Anxiety
- ☐ Depression

**Endocrine**
- ☐ Heat/Cold Intolerance

**Hematologic**
- ☐ Swell/Lymph
- ☐ Bleeding
- ☐ Abnormal Brusing

**Allergic**
- ☐ Sneezing
- ☐ Itching
- ☐ Food
- ☐ Seasonal

**Skin**
- ☐ Rash

______________________________________ ______________

**PATIENT or RESPONSIBLE PARTY SIGNATURE** **TODAY'S DATE**

**In Lieu of Signature Option, if not available, please type name and initial.**

***FOR OFFICE USE ONLY***

HEIGHT: __________ WEIGHT: __________ TEMP: __________

NOTES:

______________________________________

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