UW Medicine
VALLEY
MEDICAL CENTER

Initial Health History Form - Ear, Nose, and Throat Clinic

MEDICAL HISTORY - Has the patient had any of the following:

☐	Angina	☐	Crohn's Disease	☐	Chronic Cough
☐	Anxiety	☐	Depression	☐	Chronic Sinusitis
☐	Arrhythmia	☐	Diabetes Mellitus	☐	Headache/Migraine
☐	Asthma	☐	Dizziness/Vertigo	☐	Hearing Loss
☐	Blood Disorder	☐	Eczema/Skin Rash	☐	Hypothyroidism
☐	Cancer/Type:	☐	Emphysema	☐	Insomnia
☐	Chronic Rhinitis	☐	Gastric Reflux (GERD)	☐	Kidney Disease
☐	Cirrhosis	☐	Hay Fever/Seasonal Allergies	☐	Pituitary Tumor
☐	Clotting Disorder	☐	Heart Disease	☐	Pneumonia
☐	COPD	☐	Heart Murmur	☐	Seizure Disorder
☐	HIV/AIDS	☐	Hepatitis	☐	Stroke
☐	Rheumatic Fever	☐	Hypertension	☐	Thyroid Disease
☐	Sleep Apnea	☐	Tinnitus	☐	Tuberculosis (TB)
☐	Other:	☐		☐	

SURGICAL HISTORY - Has the patient had any of the following surgeries:

☐	Adenoidectomy	☐	Cosmetic Surgery	☐	Spine Surgery
☐	Brain Surgery	☐	Eye Surgery	☐	Thyroid Surgery
☐	Coronary Artery Angioplasty	☐	Fracture Surgery	☐	Tonsillectomy
☐	Coronary Artery Bypass Graft	☐	Nasal Polyp Removal	☐	Rhinoplasty
☐	Valve Replacement	☐	Sinus Surgery	☐	Other:

** If yes to any of the above, please provide additional details including dates:_____

MEDICATIONS: List any medication(s) the patient is taking, including any over the counter medications, vitamins and supplements. Please also include the dosage and frequency of each medication:

_____

_____

_____

_____

ALLERGIES: List any allergies and the type of reaction the patient has to medications and/or foods:

_____

_____

SOCIAL HISTORY:

Tobacco Use (please check one)

☐	Never Smoker
☐	Former Smoker - quit date: _____
☐	Current Smoker - # of packs per day: _____

Alcohol Use (please check one)

☐	No
☐	Yes - # drinks per day/week: _____

Drug Use (please check one)

☐	No
☐	Yes - Type & Frequency: _____

FAMILY HISTORY: Place an "X" in the box that relates to the patient's family medical history

Aneurysm	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Breast Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Clotting Disorder	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Colon Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Gallbladder Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Heart Attack	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Heart Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Hyperlipidemia	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Hypertension	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Kidney Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Prostate Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other
Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparents	☐ Other

☐ Family History Unknown ☐ Adopted

REVIEW OF SYMPTOMS: Are you experiencing any of the following symptoms? (check "X" all that apply)

☐	Ear Drainage	☐	Fatigue	☐	Abdominal pain
☐	Ear Pain	☐	Fever/chills	☐	Difficulty Swallowing
☐	Hearing Loss	☐	Frequent Cough	☐	Loss of appetite
☐	Hoarseness	☐	Headache	☐	Loss of balance
☐	Nasal Congestion	☐	Night Sweats	☐	Nausea/Vomiting
☐	Nasal Drainage	☐	Snoring	☐	Sinus pain/Facial Pain
☐	Pain with Speaking	☐	Swollen Glands	☐	Sore Throat
☐	Ringing in Ear	☐	Unintended weight loss	☐	Nose Bleeds
☐	Excessive thirst	☐	Loss of Smell	☐	Rash
☐	Weight gain	☐	Shortness of breath	☐	Other:

ADDITIONAL NOTES:

What is/are the main issues you would like to discuss with the doctor today?