# Southwestern Colorado Ear, Nose &Throat Associates

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**History and Physical**

**Primary Provider:**_____

**Referred By:**_____

**PATIENT'S NAME:**_____**AGE**_____**TODAY'S DATE:** _____

**PRESENT ILLNESS** (Please name the major problem or symptom that brings you to our office today)

Symptoms: _____ Date of Onset: _____

**WHAT DIAGNOSTIC TESTS HAVE BEEN DONE related to the symptoms above?** X-ray, CT Scan, MRI, Ultrasound, Swallow Study, Allergy Testing, Hearing Test, Biopsy, Other _____

**PAST HISTORY**(Please answer the following questions)

1. Do you suffer from allergies such as hayfever? Y N Asthma? Y N Eczema? Y N
   Food Allergies? Y N Latex Allergies? Y N
2. Are you allergic to any medicine or have you had a bad reaction to any medicine?
   Y N If yes, describe _____
3. Have you ever smoked? Y N Do you smoke now? Y N How many years did you smoke? _____
   How much (packs per day)?_____ Use smokeless Tobacco? Y N What year did you quit? _____
4. Do you use alcoholic beverages? Y N How much?_____ Recreational Drug Use? Y N
5. Occupation/Jobs past & present _____
6. In your jobs or hobbies have you been exposed to loud noise levels? Y N Describe_____
7. Do you have trouble understanding people? Y N Do you wear hearing aids? Y N
8. Do you drink caffeine? Y N Do you have any pets? Y N
9. Have you ever suffered a severe head injury? Y N
10. Please list the current prescription and nonprescription medications you take with dosage and frequency: (use back of form if needed or give list to receptionist) _____
    _____
11. Please list surgical procedures you have undergone _____
    _____
12. Please list current or past medical illnesses or hospitalizations_____
    _____
    _____

## SYSTEMS REVIEW (please circle any of the following which you have had or currently have)

Cancer
Location?___
_____
_____
Sugar Diabetes
Recent Weight Loss
Recent Weight Gain
Change in Appetite
Fatigue
Poor Vision
Epilepsy
Seizures or Fits
Frequent Headaches
Migraines
Fainting Episodes
Dizziness

Stroke
Spine Injury
Nervous Breakdown
Depression
Anxiety
Memory Loss
Poor Hearing
Ringing in Ears
Broken Eardrum
Frequent Ear Infection
Discharge from Ear
Hoarseness
Swollen Glands
Easy Bruising
Easy Bleeding

Anemia
Thyroid Problems
Frequent Sore Throat
Trouble Swallowing
Pneumonia
Broken Nose
Cough
Restless Sleep
Snoring
Nose Bleeds
Postnasal Drip
Stuffy Nose
Sinus Infections

Trouble Breathing
During Day
During Night
With Exercise
Chest Pain/Palpitation
Heart Trouble/Murmur
Heart Attack
High Blood Pressure
Rheumatic Fever
Joint Swelling
Joint Pain
Back/Neck Pain
Heartburn
Stomach Trouble

Ulcers
Liver Disease
Yellow Jaundice
Kidney Stones
Prostate Trouble
Chronic Pain
Where?_____
Sores Which Don't Heal
Reaction to Anesthetic
Tuberculosis
MRSA
Hepatitis
Aids
HIV Positive

**FAMILY HISTORY** (please circle any of the following which seem to run in your family or have occurred in any directly related family member - this does not include member by marriage or adoption)

Bleeding Disorders
Diabetes
Hay Fever
Thyroid Problems

Heart Disease
Asthma
Stroke
Bleeding Problems

T.B
Arthritis
Hearing Loss

Migraine
Reaction to General Anesthetic

Cancer
High Blood Pressure

**IMMUNIZATIONS** Flu? Y N Date Given _____ Pneumonia? Y N Date Given _____