Mississippi Ear, Nose & Throat SURGICAL ASSOCIATES

HISTORY

Name: _____ Age: _____ DOB: _____ Sex: _____

Preferred Pharmacy: _____ City: _____

How did you hear about us? _____

Do you know anyone else who comes here? If so, whom? _____

Are you or could you be pregnant? _____

PAST MEDICAL HISTORY - Check All That Apply

☐ Abnormal Heart Beat	☐ Diabetes Type II	☐ Hiatal Hernia	☐ Pneumonia
☐ Anxiety	☐ Emphysema	☐ High Blood Pressure	☐ Prostate Enlargement
☐ Arthritis	☐ Gastric Reflux	☐ High Thyroid	☐ Rheumatoid Arthritis
☐ Asthma	☐ Glaucoma	☐ Low Thyroid	☐ Seizures
☐ Back Pain	☐ Goiter	☐ Immune Deficiencies	☐ Stroke
☐ Bronchitis	☐ Gout	☐ Kidney Stones	☐ Ulcers
☐ Depression	☐ Heart Attack	☐ Lupus	
☐ Diabetes Type I	☐ Heart Failure	☐ Neck Pain	

☐ Cancer List Type: _____

Other: _____

PAST SURGICAL HISTORY

☐ Adenoidectomy	☐ Neck Surgery	☐ PE Tubes	☐ Tonsillectomy
☐ Ear Surgery	☐ Nose Surgery	☐ Sinus Surgery	

Other: _____

MEDICINES - List drugs you are taking on a regular basis including OTCs

Drug	Dosage

ALLERGIES

List all drugs, food, insects, etc. you are allergic to.

_____ _____ _____

_____ _____ _____

Previous Allergy Evaluation: ☐ No ☐ Yes If yes, Doctors name: _____

Previous Allergy Test Results: _____

FAMILY HISTORY - Check only if mother, father, siblings or children have condition

- ☐ Allergies
- ☐ Anesthesia Problems
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Chronic Ear Disease
- ☐ Diabetes
- ☐ Early Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer What Type: _____
- Other: _____

SOCIAL HISTORY

Smoking Status: ☐ Never ☐ Former ☐ Current

Alcohol Status: ☐ Never ☐ Former ☐ Occasionally ☐ Daily

REVIEW OF SYSTEMS - Check All That Apply

Constitutional	☐ Body Aches ☐ Chills ☐ Fever
Eyes	☐ Discharge From Eye ☐ Impaired Vision
Cardiovascular	☐ Chest Pain
Respiratory	☐ Cough ☐ Shortness of Breath ☐ Wheezing
Gastrointestinal	☐ Nausea ☐ Vomiting
Skin	☐ New Skin Lesions ☐ Rash
Neurologic	☐ Incoordination ☐ Tingling and Numbness
Endocrine	☐ Excessive Thirst ☐ Excessive Urination
Heme-Lymph	☐ Lymph Node Enlargement or Tenderness
Immunology	☐ Frequent Illness

Patient Signature:

Please sign and date this form to verify all of the above information is correct: _____