Welcome to

SOUTHERN UTAH EAR NOSE THROAT AUDIOLOGY ALLERGY & FACIAL PLASTICS

Medical History Intake Form

Name_____ Birth Date_____

Date_____

Chief complaint or illness:

What is the reason for today's visit? _____

Have you had your hearing tested in the last year? **YES NO** Is it ever difficult to understand speech? **YES NO**:

Please list any chronic illnesses or diseases you have:_____

_____

List all previous surgeries Month/Year ☐ **See Attached List**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies

_____

Medications (List all current medications, the dose you take, and how often.) ☐ **See Attached List**

1._____ Dose_____ 6._____ Dose_____

2._____ Dose_____ 7._____ Dose_____

3._____ Dose_____ 8._____ Dose_____

4._____ Dose_____ 9._____ Dose_____

5._____ Dose_____ 10._____ Dose_____

Are you currently on a pain medicine contract with any other clinic? If so please list_____

Social History:

Do you smoke or use tobacco? ☐**YES** ☐**NO** (☐Cigarettes ☐Cigars ☐Pipe ☐Chewing Tobacco)

If yes … How much? (Packs per day)_____ for _____years.

Did you quit smoking? ☐**YES** ☐**NO** If yes, WHEN? _____

Do you use alcoholic beverages? ☐**YES** ☐**NO** How much and how frequently?_____

please turn over

Do you Vape?_____ If so how often? _____

List any street drugs you have used _____

Do you have any drug or alcohol addictions? ☐ **YES** ☐ **NO** If so please list_____

Do you have any reason to believe you are at risk for HIV, AIDS, or HEPATITIS? ☐ **YES** ☐ **NO**

Medical History:

(Please check any of the following that you are **CURRENTLY EXPERIENCING** or **BEING TREATED FOR**)

ENT:

☐ Hearing loss ☐ Nose drainage ☐ Swallowing pain
☐ Loss of vision ☐ Ringing in ears ☐ Nasal Congestion ☐ Voice change
☐ Eye pain ☐ Dizziness ☐ Facial pain ☐ Snoring ☐ Ear pain
☐ Headaches ☐ Hoarseness
☐ Ear drainage ☐ Sore mouth/throat

Cardiovascular / Pulmonary

☐ Chest Pain ☐ Heart attack ☐ Irregular heartbeat

Gastrointestinal

☐ Stomach ulcers ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation
☐ Blood in stool ☐ Trouble swallowing ☐ Abdominal pain

Neurological

☐ Stroke ☐ Mini stroke (TIA) ☐ Temporary loss of vision or speech control
☐ Loss of sensation ☐ Paralysis of an arm or leg ☐ Facial paralysis

Skin

☐ Skin cancers ☐ Dermatitis/Eczema

Psychiatric

☐ Clinical depression ☐ Anxiety ☐ Schizophrenia
☐ Hallucinations ☐ Other psychiatric disorder (list)_____

Family History (please write all major illness, disease, or high-risk medical problems for parents, siblings, children)

Mother _____

Father_____

Additional comments_____

Thank you,

Southern Utah Ear Nose Throat offices **feb 2021**