

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

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 AND FILL OUT THE BACK PAGE- THANK YOU

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

Cardiovascular / Pulmonary

- Chest Pain
- Heart attack
- Irregular heartbeat

Gastrointestinal

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

Neurological

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

Skin

- Skin cancers
- Dermatitis/Eczema

Psychiatric

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

Do you have a pacemaker or any artificial heart device? _____

History of cancer? _____

History of family cancer or additional comments _____
