

**Massachusetts E.N.T. Associates  
Medical History Form**

**Date of visit:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_  
**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone: Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **ext.** \_\_\_\_\_ **Cell** \_\_\_\_\_  
**Email address:** \_\_\_\_\_  
**Name and city of Primary Care Physician:** \_\_\_\_\_  
**Name and city of Physician requesting consult:** \_\_\_\_\_  
**Primary Reason for this office visit:** \_\_\_\_\_

**Major Medical Illness:** (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

- |   |   |  |  |  |                               |
|---|---|--|--|--|-------------------------------|
| <input type="checkbox"/> High blood pressure                | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> TB   |
| <input type="checkbox"/> Emphysema/COPD                     | <input type="checkbox"/> GERD           | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Fibromyalgia                       | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Liver disease             |                               |
| <input type="checkbox"/> Atrial Fibrillation                | <input type="checkbox"/> Sleep apnea    | <input type="checkbox"/> Neuropathy    | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Other heart valve disease |                               |
| <input type="checkbox"/> Thyroid disease                    | <input type="checkbox"/> Pancreatitis   | <input type="checkbox"/> Depression    | <input type="checkbox"/> Bipolar Disease       | <input type="checkbox"/> Other Psychiatric Disease |                               |
| <input type="checkbox"/> Glaucoma                           | <input type="checkbox"/> Cataracts      | <input type="checkbox"/> HIV           | <input type="checkbox"/> Other immune disorder | <input type="checkbox"/> Bleeding disorder         |                               |
| <input type="checkbox"/> Cancer (Type and treatment: _____) |   |  |  |  |                               |
| <input type="checkbox"/> Other: _____                       |   |  |  |  |                               |

**Previous Operations:** (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

- |  |  |   |  |   |   |
|--|--|---|--|---|---|
| <input type="checkbox"/> Tonsillectomy   | <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Ear tubes      | <input type="checkbox"/> Other ear surgery | <input type="checkbox"/> Septoplasty                      | <input type="checkbox"/> Sinus surgery  |
| <input type="checkbox"/> Rhinoplasty     | <input type="checkbox"/> Gall bladder  | <input type="checkbox"/> Appendix       | <input type="checkbox"/> Lung surgery      | <input type="checkbox"/> AV fistula                       | <input type="checkbox"/> Kidney surgery |
| <input type="checkbox"/> Brain surgery   | <input type="checkbox"/> Joint surgery | <input type="checkbox"/> Back surgery   | <input type="checkbox"/> Carotid surgery   | <input type="checkbox"/> Heart surgery                    | <input type="checkbox"/> Eye surgery    |
| <input type="checkbox"/> Thyroid surgery | <input type="checkbox"/> G-tube        | <input type="checkbox"/> Gastric bypass | <input type="checkbox"/> Colon surgery     | <input type="checkbox"/> Other stomach/intestinal surgery |   |
| <input type="checkbox"/> Other: _____    |  |   |  |   |   |

**Current Medications (Including Aspirin/Herbal medicines/Over the counter medications):**

**Allergies to medications, foods and environmental causes:**

**Family History:** (Please check boxes to indicate "yes"; boxes left empty will indicate "no")

- |   |   |  |  |  |                               |
|---|---|--|--|--|-------------------------------|
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| <input type="checkbox"/> Emphysema/COPD                     | <input type="checkbox"/> GERD           | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Fibromyalgia                       | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Liver disease             |                               |
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| <input type="checkbox"/> Thyroid disease                    | <input type="checkbox"/> Pancreatitis   | <input type="checkbox"/> Depression    | <input type="checkbox"/> Bipolar Disease       | <input type="checkbox"/> Other Psychiatric Disease |                               |
| <input type="checkbox"/> Glaucoma                           | <input type="checkbox"/> Cataracts      | <input type="checkbox"/> HIV           | <input type="checkbox"/> Other immune disorder | <input type="checkbox"/> Bleeding disorder         |                               |
| <input type="checkbox"/> Cancer (Type and treatment: _____) |   |  |  |  |                               |
| <input type="checkbox"/> Other: _____                       |   |  |  |  |                               |

**Social History: Have you ever smoked?**  Yes  No **How many years?** \_\_\_\_\_  
**How much?** aaaaaa \_\_\_\_\_ **When did you quit?** \_\_\_\_\_

**Alcoholic beverages per day:** \_\_\_\_\_  
**Recreational drugs: Prior use?**  Yes  No **Current use?**  Yes  No

**Occupation:** \_\_\_\_\_  
**Hobbies:** \_\_\_\_\_ **Do you use your voice professionally?**  Yes  No

**Patient Name:** \_\_\_\_\_ **Date of visit:** \_\_\_\_\_

**Review of Systems:** Do YOU have: (Please check boxes to indicate “yes”; boxes left empty will indicate “no”)

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Loss of Hearing            | <input type="checkbox"/> Ringing in ears/tinnitus     | <input type="checkbox"/> Dizziness/vertigo              | <input type="checkbox"/> Hearing aids                   |
| <input type="checkbox"/> Sense of ear blockage      | <input type="checkbox"/> Ear pain                     | <input type="checkbox"/> Ear drainage                   | <input type="checkbox"/> Family history of hearing loss |
| <input type="checkbox"/> Facial weakness            | <input type="checkbox"/> Previous ear surgery         | <input type="checkbox"/> Exposure to loud noise         |   |
| <input type="checkbox"/> Nose bleeds                | <input type="checkbox"/> Nasal congestion/obstruction | <input type="checkbox"/> Nasal discharge                | <input type="checkbox"/> Post nasal drip                |
| <input type="checkbox"/> Loss of sense of smell     | <input type="checkbox"/> Nasal polyps                 | <input type="checkbox"/> Concern about nasal appearance |   |
| <input type="checkbox"/> Sinus problems             | <input type="checkbox"/> Facial pain                  |   |   |
| <input type="checkbox"/> Recurrent sore throats     | <input type="checkbox"/> Hoarseness                   | <input type="checkbox"/> Trouble/pain with swallowing   |   |
| <input type="checkbox"/> Neck swelling/mass         | <input type="checkbox"/> Neck infections              | <input type="checkbox"/> Thyroid disease/nodule/goiter  |   |
| <input type="checkbox"/> Chest pain/pressure        | <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Cough                          | <input type="checkbox"/> Wheezing                       |
| <input type="checkbox"/> Abdominal pain             | <input type="checkbox"/> Diarrhea                     | <input type="checkbox"/> Constipation                   | <input type="checkbox"/> Heartburn/indigestion          |
| <input type="checkbox"/> Nausea/vomiting            | <input type="checkbox"/> Problems with urination      |   |   |
| <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Numbness                     | <input type="checkbox"/> Paralysis                      | <input type="checkbox"/> Headaches                      |
| <input type="checkbox"/> History of migraines       | <input type="checkbox"/> Vision problems              |   |   |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Easy bleeding or bruising    | <input type="checkbox"/> Fevers                         | <input type="checkbox"/> Unexplained weight loss        |
| <input type="checkbox"/> Joint pain                 | <input type="checkbox"/> Muscle weakness              | <input type="checkbox"/> Osteoporosis                   |   |
| <input type="checkbox"/> Skin disorders/diseases    |   |   |   |
| <input type="checkbox"/> Second hand smoke exposure |   |   |   |

**FEMALE PATIENTS:** Are you pregnant?  No  Yes (Number of weeks: \_\_\_\_\_ )

**Tests and studies:** Have you had any tests or studies relevant to today's visit? If yes, please note these below:

- | <b>Test</b>  | <b>Hospital where test was performed</b> |   |
|--|--|---|
| <input type="checkbox"/> XRAY/CT/MRI   | _____                                    | → Part of body (e.g. sinuses, adenoids, ears, neck, etc.):<br>_____ |
| <input type="checkbox"/> Neck/Thyroid Ultrasound                             | _____                                    |   |
| <input type="checkbox"/> Thyroid blood tests                                 | _____                                    |   |
| <input type="checkbox"/> Swallowing study                                    | _____                                    |   |
| <input type="checkbox"/> Hearing test(s)                                     | _____                                    |   |
| <input type="checkbox"/> Allergy tests                                       | _____                                    |   |
| <input type="checkbox"/> Biopsies of the ear, nose,<br>throat, face, or neck | _____                                    |   |

Please list any other pertinent medical information that may be helpful to the doctor, as well as any other concerns you would like addressed during your office visit: