DAVID M. DAVIS, M.D.
JEFFREY S. WEINGARTEN, M.D.
C. BART DICKSON, M.D.
MICHAEL E. STONE, M.D.
WALTER M. BELENKY, M.D.

OTOLARYNGOLOGY
HEAD AND NECK SURGERY
FACIAL PLASTIC SURGERY

NAME (please print): ____DATE: ______________

COMPREHENSIVE HISTORY EVALUATION

Please complete the following medical history form. This will assist your physiscian in making your diagnosis and instituting your treatment.

EAR PROBLEMS		NOSE PROBLEMS		THROAT PROBLEMS	
Hearing Loss	☐	Blocked	☐	Sore Throat	☐
Dizziness	☐	Drainage	☐	Difficlty swallowing	☐
Ringing or other noise	☐	Bleeding	☐	Voice change - Hoarse	☐
Drainage	☐	Sneezing	☐	Cough	☐
Pain	☐	Loss of smell	☐		
		Facial pain	☐	Other:	
Other:					
		Other:			

Which of the above is the main problem? ☐ Ears ☐ Nose ☐ Throat

Present Medical Illnesses:

Present Medications:

Present allergies to medication(s) (please indicate if your reaction was a rash, breathing difficulty, etc.):

PAST MEDICAL HISTORY AND SYSTEM REVIEW

Injuries:

Past Surgeries:

Hospitalizations:

Do you use alcohol? ☐ yes ☐ no How much and for how long? ____________________

Do you smoke? ☐ yes ☐ no How much and for how long? ____________________

PAST MEDICAL HISTORY AND SYSTEM REVIEW (continued)

METABOLIC:

Diabetes	☐ yes	☐ no
Blood clots	☐ yes	☐ no
Bleeding problems	☐ yes	☐ no
Anemia	☐ yes	☐ no
Thyroid disorders	☐ yes	☐ no
Personal or family problems with anesthesia	☐ yes	☐ no
Others	☐ yes	☐ no

HEART PROBLEMS:

Myocardial infarction (Heart Attack)	☐ yes	☐ no
Angina (Chest Pain)	☐ yes	☐ no
Arrythmia (Skipped Beats)	☐ yes	☐ no
Heart Murmur	☐ yes	☐ no
Mitral Valve Prolapse	☐ yes	☐ no
High Blood Pressure (Hypertension)	☐ yes	☐ no

LUNG PROBLEMS:

Emphysema / COPD	☐ yes	☐ no
Tuberculosis (T.B.)	☐ yes	☐ no
Asthma	☐ yes	☐ no
Shortness of breath	☐ yes	☐ no
Pneumonia	☐ yes	☐ no

INFECTIOUS DISEASES:

Herpes	☐ yes	☐ no
V.D. / Syphilis	☐ yes	☐ no
A.I.D.S. - H.I.V.	☐ yes	☐ no
Hepatitus (Jaundice)	☐ yes	☐ no
Infectious Mono (When?)	☐ yes	☐ no
Meningitis	☐ yes	☐ no
Polio	☐ yes	☐ no

NEUROLOGIC:

Alterations in vision (other than glasses or cataracts)	☐ yes	☐ no
Seizures / Convulsions	☐ yes	☐ no
Strokes / C.V.A.	☐ yes	☐ no
Psychiatric Disorders	☐ yes	☐ no

GASTROINTESTINAL / RENAL:

Ulcers	☐ yes	☐ no
Vomiting Blood	☐ yes	☐ no
Abdominal Pain	☐ yes	☐ no
Kidney Disease	☐ yes	☐ no
Kidney / Bladder Infections	☐ yes	☐ no

CANCERS / TUMORS (please describe)

FAMILY MEDICAL CONDITIONS:

Heart Problems	☐ yes	☐ no
High Blood Pressure	☐ yes	☐ no
Lung Problems	☐ yes	☐ no
Anesthesia Problems	☐ yes	☐ no
Diabetes	☐ yes	☐ no

PATIENT’S SIGNATURE ____ DATE____________________

WE THANK YOU FOR YOUR ASSISTANCE IN THE EVALUATION OF YOUR HEALTH