Michigan ENT & Allergy Specialists

New Patient Health History

Name: _____ Date of Birth: _____ Date: _____

Email Address: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Referring Physician: _____

Other physician(s): _____

Marital Status: _____ Gender: ❑ Male ❑ Female Height: _____ Weight: _____

Preferred Pharmacy: _____

Please list family members that are patients or have been seen in our office: _____

Please answer the following the best you can. Some of these may be difficult to answer and the medical staff will assist you when you are brought to the exam room. Anything left blank will be assumed normal / not present.

Chief Complaint: _____

_____

Location/site of the problem: _____

Quality of the problem (e.g. sharp or dull pain): _____

Severity of the problem (e.g. mild, moderate, severe): _____

Timing/duration of the problem (e.g. at night, one week): _____

Context (e.g. worsening, improving, recurrent): _____

Modifying factors (things that make it better or worse): _____

Associated signs or symptoms: _____

MEDICATIONS
Please list all prescription and nonprescription medicines

Medicine	Dose	How often
Example: Aspirin	81 mg	once a day

ALLERGIES / SENSITIVITIES
(Medicines, environmental and food

Allergy	Side Effects

SOCIAL HISTORY

Occupation: _____ ❑ Working ❑ Retired ❑ Unemployed ❑ N/A

Are you under an excessive amount of stress? ❑ Yes ❑ No ❑ N/A

❑ NO Tobacco Exposure ❑ Tobacco Exposure—Explain: _____ Age began _____

Years Smoked _____ Average pack per day _____ Age quit _____

Alcohol use? ❑ Yes ❑ No If yes: number of drinks per week: _____

Drugs use? ❑ Yes ❑ No If yes: please describe: _____

Please complete both front and back of this questionnaire.

PAST SURGICAL / MAJOR ILLNESS HISTORY (List as accurately as possible when, what and why.)

1. _____ 2. _____

3. _____ 4. _____

FOR PEDIATRIC PATIENTS ONLY:

Was your child a product of a normal pregnancy & delivery? ❑ Yes ❑ No Please explain: _____

Is your child in a daycare setting? ❑ Yes ❑No Pease explain: _____

Is your child's immunizations up to date? ❑ Yes ❑ No Please explain: _____

FAMILY HISTORY – Do any of your family members have the following?

	YES	NO	RELATIONSHIP
Diabetes	❑	❑	_____
High blood pressure	❑	❑	_____
Heart disease	❑	❑	_____
Cancer	❑	❑	_____
Hearing loss	❑	❑	_____
Asthma	❑	❑	_____
Stroke	❑	❑	_____
Respiratory failure	❑	❑	_____
Bleeding disorders	❑	❑	_____
Anesthetic complications	❑	❑	_____ Explain: _____
Other inherited diseases	❑	❑	_____ Explain: _____

PATIENT MEDICAL HISTORY – pertaining only to the patient

	YES	NO	EXPLAIN
Bleeding Problems	❑	❑	_____
Cancer	❑	❑	_____
Skin changes	❑	❑	_____
Ear, Nose, Throat problems (unrelated to today's visit)	❑	❑	_____
History of fever, weight loss or chills	❑	❑	_____
Visual Changes	❑	❑	_____
Hearing problems or ringing in the ears	❑	❑	_____
History of noise exposure	❑	❑	_____
Are you pregnant (women only)	❑	❑	_____
Claustrophobia	❑	❑	_____
Cardiovascular problems (ex: Heart attack, chest pain)	❑	❑	_____
Respiratory problems (ex: Asthma, wheezing)	❑	❑	_____
Gastrointestinal problems (ex: Bloody stools, ulcers)	❑	❑	_____
Genitourinary problems (ex: Painful, bloody urination	❑	❑	_____
Musculoskeletal problems (ex: Arthritis)	❑	❑	_____
Neurological problems (ex: Stroke, seizures)	❑	❑	_____
Psychiatric problems (ex: Depression, anxiety)	❑	❑	_____
Endocrine problems (ex: Diabetes, low thyroid)	❑	❑	_____
Immune problems (ex: AIDS, immune deficiencies)	❑	❑	_____

Signature_____

Please complete both front and back of this questionnaire.