Patient Medical History Form
Otolaryngology, Head & Neck Surgery

330 S. Garden Way, Suite 300
Eugene, OR 97401
(541) 334-3370

Patient Name _____

Date of Birth _____

Primary/Referring Doctor _____

Pharmacy _____

What is the reason for your visit today? _____

MEDICAL HISTORY Please check the box to indicate whether you have/had any of the following illnesses

Respiratory problems: ☐ Asthma ☐ COPD ☐ Tuberculosis

Allergy problems: ☐ Allergic Rhinitis

Kidney problems: ☐ Kidney Disease ☐ Kidney Stones

Thyroid problems: ☐ Hyperthyroidism ☐ Hypothyroidism

Diabetes: ☐ Type 1 ☐ Type 2

Stomach or Intestinal problems: ☐ GERD ☐ GI Bleed ☐ Peptic Ulcers

Liver problems/Hepatitis: ☐ Sarcoidosis ☐ Cirrhosis ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Liver Disease

Heart disease: ☐ Atrial Fibrillation ☐ CVA/Stroke ☐ Coronary Heart Disease ☐ Valvular Heart Disease ☐ Myocardial Ischemic Attack

Neurological Problems: _____

Cancer (indicate type): _____

Other Medical Diagnoses: _____

MEDICATION ALLERGIES:

Please list any **OPERATIONS** (and dates) you have ever had (*including tonsils & adenoids*) below:

_____

_____

Please provide the following medical information to the best of your ability:

FAMILY HISTORY Please check the "Yes" or "No" box to indicate whether any ***relatives*** have any of the following illnesses.

	YES	NO			YES	NO	
Bleeding Disease	☐	☐	_____	Heart Disease	☐	☐	_____
Anesthesia Problems	☐	☐	_____	Diabetes	☐	☐	_____
Hearing Loss	☐	☐	_____	Cancer	☐	☐	_____
Allergies	☐	☐	_____	Migraines	☐	☐	_____
Thyroid Disease	☐	☐	_____				

SOCIAL HISTORY

What is your marital status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

What is your occupation? _____

IF A PATIENT IS A CHILD, please provide the following information:

Parent/Guardian Name(s): _____

Child is here with: _____

Circle all that apply: Daycare Preschool Grade ___ Smoker(s) in house ___ Foster Care

PLEASE TURN OVER AND CONTINUE ON REVERSE SIDE

Please list any **CURRENT MEDICATIONS** (amounts and times per day taken):

(Include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy medications):

☐ Current OMG patient, medications reviewed on electronic medical record.

_____

_____

_____

RISK FACTORS	**YES**	**NO**	*Please list details below.*
Do you drink alcohol? List how much.	☐	☐	
Do you smoke? List how much.	☐	☐	
If no, did you smoke previously?	☐	☐	
Do you use cigars/pipes/oral tobacco?	☐	☐	
If no, did you use previously?	☐	☐	
Caffeine intake? List daily amount.	☐	☐	
Do you use illicit drugs?	☐	☐	

DO YOU HAVE AN ADVANCED DIRECTIVE? ☐ **YES** ☐ **NO**

REVIEW OF SYSTEMS Please check the "Yes" or "No" box to indicate whether you **presently** have any of the following symptoms:

		YES	NO		YES	NO
EARS:	ear pain	☐	☐	ringing/head noise	☐	☐
	drainage	☐	☐	dizziness	☐	☐
	hearing loss	☐	☐			
NOSE:	sinusitis	☐	☐	altered sense of smell	☐	☐
	nasal obstruction	☐	☐			
THROAT:	hoarseness	☐	☐	post nasal drainage	☐	☐
	sore throat	☐	☐	snoring	☐	☐
	difficulty swallowing	☐	☐			
ALLERGY:	hives	☐	☐	throat irritation	☐	☐
	nasal congestion	☐	☐	chronic cough	☐	☐
	itchy eyes	☐	☐	dry cough	☐	☐
RESPIRATORY:	coughing blood	☐	☐	wheezing	☐	☐
	pain with breathing	☐	☐	productive cough	☐	☐
	shortness of breath	☐	☐			
CARDIAC:	chest pain	☐	☐	rapid/irregular heartbeats	☐	☐
GI:	heartburn	☐	☐	abdominal bloating/excessive gas	☐	☐
GENERAL:	fatigue	☐	☐	weight gain/loss	☐	☐
	night sweats	☐	☐			
EYES:	blurred vision	☐	☐	double vision	☐	☐
NEUROLOGIC:	headache	☐	☐	numbness	☐	☐
SKIN:	skin growths/moles	☐	☐			
HEME:	bleed easily	☐	☐	joint pain	☐	☐
	bruise easily	☐	☐	lymph node swelling	☐	☐
PSYCH:	depression	☐	☐			

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? Please circle answer:

Little interest or pleasure in doing things:	not at all	several days	more than half the days	nearly everyday
Feeling down, depressed or hopeless:	not at all	several days	more than half the days	nearly everyday