MERITAS HEALTH
ENT

# *MERITAS HEALTH EAR, NOSE, & THROAT*

MEDICAL HISTORY

Patient Name_____

Reason for seeing Doctor_____ Referring Doctor_____

REVIEW OF SYSTEMS: Do you have any or the following?

Constitutionals Fever_____ Chills_____

EAR: Pain____ Hearing Loss____ Ringing____ Noise Exposure____ Pressure____ Dizziness____

NOSE/SINUS: Breathing Problems____ Pressure/Headaches____ Discharge____ Congestion____
Snoring____ Infections____

SKIN: Rash_____ Swelling/Irritations_____

THROAT: Pain____ Hoarseness____ Difficulty Swallowing____ Cough____

EYE: Draining____ Red and itch____

Other Symptoms:
Diabetes____ Heart Trouble____ High Blood Pressure____ Bleeding Tendency____
Bruise Easily____ Kidney Trouble____ TB____ Ulcer____ Arthritis____ Allergies____ Other____

Have you been exposed to the HIV (Aids) Virus? Y or N

PAST HISTORY: Prior/Present Illness_____

List Previous Surgery:_____
_____

FAMILY HISTORY:
Hearing Loss____ Cancer____ Diabetes____ Others_____

PHARMACY YOU USE_____

Signature_____
Relationship to Patient_____
Information reviewed on Date_____

MERITAS HEALTH

ENT

# Meritas Health Ear, Nose and Throat

PATIENT NAME_____ DOB_____

## MEDICATIONS

| DAILY MEDS | EPISODIC MEDS AND DATE |
|---|---|
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## DRUG ALLERGIES

| NAME OF MEDICATION | REACTION |
|---|---|
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MERITAS HEALTH
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# Adult History Form

**Family History**

Indicate if any blood relatives have had any of these conditions: Alcoholism, Arthritis, Asthma, Hay Fever, Cancer, Cirrhosis, Diabetes, Emphysema, Epilepsy, Gout, Heart, High Blood Pressure, Kidney Disease, Kidney Stones, Migraines, Sickle Cell, Stroke, Suicide, Mental Illness, Thyroid, Tuberculosis, Bleeding Tendency

| Family Member | Alive/Deceased | Year of birth | Medical conditions, if any |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother 1 | | | |
| Brother 2 | | | |
| Brother 3 | | | |
| Sister 1 | | | |
| Sister 2 | | | |
| Sister 3 | | | |
| Paternal grandfather | | | |
| Paternal grandmother | | | |
| Maternal grandfather | | | |
| Maternal grandmother | | | |

| | | Number | | Number | Healthy? |
|---|---|---|---|---|---|
| **Siblings** | Brothers | | Sisters | | |
| **Children** | Sons | | Daughters | | |

Additional family history:

| |
|---|
| |
| |
| |

# Wellness Update

**Patient Name**_____ **DOB**_____ **TODAYS DATE**_____

| Do you experience any of these symptoms? | *Yes* | *No* |
|---|---|---|
| Runny Nose | | |
| Itchy Nose | | |
| Stuffy Nose | | |
| Itchy Eyes | | |
| Watery Eyes | | |
| Frequent Sneezing | | |
| Itchy Mouth/Lips/Throat | | |
| Post Nasal Drip (drainage down the back of the throat, clearing throat) | | |

**How often do you experience these symptoms?**

D Occasionally (2-3 times per year)

D Over 3 times a year

D A few long periods of time per year (Spring, Summer, Fall, Winter)

D Most of the year

**Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms?** D Yes D No

**Please indicate below symptoms/conditions you've experienced during the last 1-2 years**

D Sinus related issues (sinus pressure/pain, headaches, sinusitis)

D Re-occurring Seasonal Colds

D Chronic colds (lasting longer than 2 months)

D Migraine Headaches

D Restless sleep, challenges sleeping through the night, snoring

D Consistent or Re-occurring coughing

D Feeling of fatigue, irritability, & restlessness

D Asthma

D Skin conditions (dry and/or itchy skin, etc...)

1/17/2014

**Patient Signature**_____ **Date**_____

**FOR PHYSICIANS ONLY**

**Physician Wish to have allergy testing yes ☐ no ☐**
**After Medical Management yes ☐ no ☐ Time frame**_____
**Uncertain CAS Review ☐ Diagnosis**_____
**Provider Signature**_____ **Date**_____

**FOR CAS USE ONLY:**
**Date of Last ENT Exam:** _____