

**Coastal Ear, Nose & Throat Associates, PLLC---- Patient History Form**

Full Name \_\_\_\_\_ Appointment Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

Pharmacy Preference \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

What is your reason for today's visit? \_\_\_\_\_

When did this start? \_\_\_\_\_ Where is it located? \_\_\_\_\_

What makes this problem worse? \_\_\_\_\_

Are any of the following symptoms associated with this problem? Please circle answer

- |  |   |
|--|---|
| Hearing loss..... <input type="checkbox"/> Yes <input type="checkbox"/> No           | Mouth Sores ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Ringing in Ears..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | Coughing..... <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Pain in Ears..... <input type="checkbox"/> Yes <input type="checkbox"/> No           | Dizziness..... <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Drainage in Ears ..... <input type="checkbox"/> Yes <input type="checkbox"/> No      | Watery Eyes..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Nasal Drainage ..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | Difficulty Swallowing..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sore Throat..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | Hoarseness..... <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Swollen glands in Neck..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Other..... <input type="checkbox"/> Yes (explain below) <input type="checkbox"/> No |

**Are you taking ANY kind of medication?** (Include prescription, over-the-counter or herbal medications)

No Yes If yes, please list below with dosages.

<u>Medication</u>	<u>Dosage</u>	<u>How often taken</u>

**Are you allergic to any medications?** No Yes If yes, please list below.

<u>Name of medication</u>	<u>Type of reaction</u>

**Surgeries and Hospitalizations**

Have you had any problems with anesthesia (being numbed or put to sleep)? No Yes

Have you had any ear, nose or throat surgery? No Yes (type and date) \_\_\_\_\_

List any other surgeries you have had: \_\_\_\_\_

Have you ever been hospitalized? No Yes If so, please explain \_\_\_\_\_