**Collin County ENT**

**Ewen Tseng, M.D. Keith Matheny, M.D. Kenny Carter, Jr., M.D. Mark Littlejohn, M.D.**

**Jessica Teed, PA-C Chad Bailey, PA-C**

**PATIENT HEALTH HISTORY**

**Patient’s Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M\_\_\_\_\_\_\_\_\_\_\_**

**Sex \_\_\_Male \_\_\_Female Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Primary Care Physician** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Preference (including location & number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR TODAY’S VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:**

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dosage** | **How Often Taken** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ARE YOU ALLERGIC TO ANY MEDICATION? \_\_\_\_YES \_\_\_\_NO If so, please list below:**

|  |  |
| --- | --- |
| **Name of Medication** | **Type of Reaction** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**SURGERIES AND HOSPITALIZATIONS**

**Have you ever had any problems with anesthesia (being numbed or put to sleep)? \_\_\_**YES\_\_\_NO

**If so, list type of problems:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any surgeries you have had (including dates):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been hospitalized for non-surgical reasons?** \_\_\_YES \_\_\_NO

**If so, list reasons for hospitalizations**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT OR MOST RECENT OCCUPATION**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you allergic to any of the following? Indicate yes with check mark.**

Adhesive tape\_\_\_\_ Metal\_\_\_\_ Iodine\_\_\_\_ Seafood\_\_\_\_ LATEX\_\_\_\_ Contrast dye\_\_\_\_

**Mark if you have been diagnosed with any of the following?**

* Breast cancer
* Lung cancer
* Skin cancer
* Throat cancer
* Prostate cancer
* Other cancers
* Migraine headaches
* Cataracts
* Glaucoma
* Nasal allergies
* Sleep apnea
* Blood clots/DVT
* High cholesterol
* Heart attack
* High blood pressure
* Asthma
* Chronic bronchitis
* Emphysema
* Tuberculosis
* Reflux
* Hepatitis
* Stomach Ulcer
* Are you pregnant?
* Prostate enlargement
* Renal Failure
* Stroke
* Anxiety
* Depression
* Diabetes
* Thyroid dysfunction
* Anemia
* Hemophilia
* HIV

**List other medical diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mark family members who have been diagnosed with any of the following:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Mother** | **Father** | **Sister** | **Brother** |
| **Problems with anesthesia** |  |  |  |  |
| **Thyroid cancer** |  |  |  |  |
| **Lung cancer** |  |  |  |  |
| **Unspecified cancer** |  |  |  |  |
| **Hearing loss before age 20** |  |  |  |  |
| **Hearing loss after age 20** |  |  |  |  |
| **Heart disease** |  |  |  |  |
| **High blood pressure** |  |  |  |  |
| **Asthma** |  |  |  |  |
| **Stroke** |  |  |  |  |
| **Diabetes** |  |  |  |  |
| **Bleeding/clotting problem** |  |  |  |  |

**Mark your tobacco use:** \_\_\_\_\_NONE \_\_\_\_\_SMOKELESS TOBACCO \_\_\_\_CIGARETTES \_\_\_\_CIGARS **Closest number of cigarettes in an average day**: \_\_\_½ pack \_\_\_1 pack \_\_\_ 1½ packs \_\_\_2 packs \_\_\_3 packs

**Alcoholic Beverages: (A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.)**

 \_\_\_\_less than 12 drinks/year \_\_\_\_1-12 drinks/month \_\_\_\_4-14 drinks/week \_\_\_\_>2 drinks/day

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use drugs recreationally?** \_\_\_\_\_Yes \_\_\_\_\_No

**Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):**

 \_\_\_\_none \_\_\_\_1/day \_\_\_\_2-3/day \_\_\_\_4 or more/day

**Are you exposed to second hand smoke?** \_\_\_\_Yes \_\_\_\_No

**Mark if patient attends daycare** \_\_\_Yes

**Will you accept transfusions of blood products?** \_\_\_\_Yes \_\_\_\_No

**Home living situation (mark all that apply):**

* Alone
* With children
* With mother
* Assisted Living
* With spouse
* In nursing facility
* With father
* Other

**Do you now have or have you recently had any of the following?**

* Fever
* Sleeping problems
* Unintentional weight loss
* Unintentional weight gain
* Blurred vision
* Itchy eyes
* Loss of vision
* Painful eye
* Dizziness
* Ear drainage
* Hearing loss
* Ear pain
* Ringing in the ears
* Nasal congestion
* Frequent nosebleeds
* Post nasal drainage
* Belching sour material into throat
* Hoarseness/Other voice changes
* Mouth ulcers
* Partials or dentures
* Blacking out or fainting
* Chest pain
* Heart murmur
* Irregular heartbeats
* Leg cramps
* Swelling of ankles
* Frequent non-productive cough
* Frequent productive cough
* Shortness of breath
* Snoring
* Wheezing
* Abdominal pain
* Diarrhea
* Heartburn
* Nausea
* Trouble swallowing
* Painful swallowing
* Vomiting
* Painful joints
* Stiffness in joints
* Swelling of joints
* Change in sense of smell
* Change in sense of taste
* Headache
* Severe face pain
* Seizures
* Tremor
* Appetite is increased
* Fatigue
* Cold feeling
* Bleed excessively after injury
* Bruise easily
* Masses (lumps) in armpit
* Masses (lumps) in neck
* Masses (lumps) in groin
* Hives
* Sneezing