Orlando Ear, Nose & Throat Associates, PA

Health History

Name____BirthDate_____________________

Please check if you have or have had any of the following conditions, symptoms, or surgery.

Symptoms:

Ears/Nose/Throat

___Ear pain

___Loss of hearing

___Ear discharge

___Noise in ears

___Congestion

___Difficulty swallowing

___Cough

___Nasal discharge

___Sore throat

___Hoarseness

___Skin changes

___Neck pain

___Nose bleeds

___Shortness of breath

___Indigestion

___Heartburn

___Snoring

___Other__________________

Conditions:

___Anemia

___Arthritis

___Asthma

___Bleeding disorder
(type__________________)

___Cancer (type__________________)

___Colitis/Chrohn's

___Diabetes

___Emphysema/COPD

___Gastroesophageal Reflux

___Headaches/Migraines

___Heart disease

___Hypertension/High Blood Pressure

___Liver disease

___Sleep Apnea

___Stroke

___Other ________________

Surgery:

___Tonsillectomy/T&A

___Sinus/Septum

___Ear/ Tubes

___Plastic
(type_____________________)

___Thyroid

___Spinal

___Brain/Cranial

___Cardiac bypass

___Cardiac stents

___Carotid

___Intestinal

___Gallbladder

___Hernia

___Pacemaker

___Weight Loss
(type_____________________)

___Other__________________

Do you use any sleep apnea treatment?

_____CPAP _____BiPAP _____Oxygen _____Jaw Positioning Device

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Health History

Name____BirthDate________________________

Please list all current medications being taken:

____

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____

Please list any over the counter medications and natural/herbal supplements being taken:

____

____

____

Please list any known **allergies** to medication:

____

____

____

Do you use tobacco?____________packs per day/ ____________cans/bags per day

Do you drink alcohol?_____________drinks per day

Do you use caffeine?______________drinks per day

Is there anything else about your health you would like us to know?

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