

Medical and Surgical History

Welcome to Greenwood, Laurens, Newberry & Abbeville Ear, Nose & Throat Centers
Please help us serve you better by completing your medical history
before you see the Doctor.
Your medical record is strictly confidential.

Name: _____ age: _____ date: _____

Referring Physician: _____ Regular Physician: _____

Location & name of the Pharmacy you use: _____

Reason you are seeing the doctor today? _____

How long have you had this problem? _____

How many times have you been treated for this problem in the past year? _____

What medications or tests have you received for this problem in the past? _____

Past medical history:

List all previous *medical problems*: _____

List all previous *surgeries*: _____

Please list your *daily medications*: (with doses, remember to include lotions, drops, birth control pills, and any recreational drugs) _____

Please list any medications, food, or environmental *allergies*: _____

Social history:

Do you now or did you *smoke tobacco*? _____ packs/day? _____

Do you use *smokeless tobacco*? _____ packs/day? _____

Do you *drink alcohol or beer*? _____ amount per week? _____

Family history:

Please list any illnesses, which run in your family. Include any bleeding disorders, or bad reactions to anesthesia during surgery. _____

Other information you would like the doctor to know: _____

Emergency: _____

Contact: _____

TO HELP US SERVE YOU BETTER
PLEASE MARK "YES" OR "NO" TO THE FOLLOWING QUESTIONS
BEFORE YOU SEE THE DOCTOR

GENERAL YES NO

- | | | |
|-----------------|--------------------------|--------------------------|
| 1. Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chills | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Weight loss | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Night sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Other _____ | | |

EARS YES NO

- | | | |
|---------------------------|--------------------------|--------------------------|
| 1. Hearing loss - gradual | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Hearing loss - sudden | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ringing | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Dizziness or vertigo | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Frequent infections | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other _____ | | |

NOSE YES NO

- | | | |
|-------------------|--------------------------|--------------------------|
| 1. Nose bleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Injury | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Congestion | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Runny nose | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mouth breather | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other _____ | | |

THROAT YES NO

- | | | |
|-------------------------------|--------------------------|--------------------------|
| 1. Frequent sore throats | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Foreign body | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Swollen tonsils | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Sleep Apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Trouble breathing at night | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Snoring | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Daytime sleepiness | <input type="checkbox"/> | <input type="checkbox"/> |

EYES YES NO

- | | | |
|---------------------|--------------------------|--------------------------|
| 1. Cataracts | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Distorted vision | <input type="checkbox"/> | <input type="checkbox"/> |

HEART YES NO

- | | | |
|--------------------------|--------------------------|--------------------------|
| 1. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Irregular heart beat | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Previous heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Other _____ | | |

LUNGS YES NO

- | | | |
|-----------------------------|--------------------------|--------------------------|
| 1. Bronchitis/chronic cough | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Asthma/wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Congestion | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Other _____ | | |

GASTROINTESTINAL YES NO

- | | | |
|----------------------------|--------------------------|--------------------------|
| 1. Indigestion / heartburn | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Diverticulitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Gall bladder trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Nausea & vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other _____ | | |

URINARY TRACT YES NO

- | | | |
|----------------------------|--------------------------|--------------------------|
| 1. Kidney problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Painful urination | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Bloody urination | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Prostate problems (men) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Other _____ | | |

MUSCULOSKELETAL YES NO

- | | | |
|----------------------|--------------------------|--------------------------|
| 1. Back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Weakness of limbs | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Other _____ | | |

NEUROLOGICAL YES NO

- | | | |
|-----------------------|--------------------------|--------------------------|
| 1. Numbness | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Migraine headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other _____ | | |

ENDOCRINE YES NO

- | | | |
|-------------------------|--------------------------|--------------------------|
| 1. Thyroid disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Menopause (women) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Hormonal replacement | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Pregnant (women) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other _____ | | |

BLOOD DISORDERS YES NO

- | | | |
|---------------------|--------------------------|--------------------------|
| 1. Low blood counts | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Free bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Blood clots | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Blood disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other _____ | | |

ALLERGY/IMMUNE YES NO

- | | | |
|----------------------------|--------------------------|--------------------------|
| 1. Seasonal allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Itchy eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Runny nose | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Allergy testing in past | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. HIV or AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other _____ | | |