

Today's Date: _____

Spokane Valley Ear, Nose & Throat and Facial Plastic Surgery

New Patient History Form

Name: _____ DOB: _____ Age: _____

Referring Physician: _____

Reason for Your Visit: _____

How Long Have You Had Symptoms? _____

Past Medical History

Circle which of the following you have or had:

Please Specify:

Diabetes/ thyroid /endocrine problems _____

Heart / vascular problems _____

Lung problems/ asthma /pneumonia _____

Kidney or urinary problems _____

Liver problems or viral hepatitis _____

Bleeding or clotting problems _____

Cancer or any tumors _____

Neurologic/ brain problems /headaches _____

Depression/ anxiety /psychiatric _____

HIV or AIDS _____

Osteoarthritis or joint problems _____

Rheumatoid arthritis/ lupus /autoimmune _____

Hearing or vertigo disorders _____

Gastroesophageal reflux / esophageal _____

Speech or swallowing disorders _____

Sinus/ nasal /eye /facial problems _____

Skin disorders _____

Sleep Disorders/Apnea/CPAP _____

Past Surgical History

List all surgeries you have had:

Family History

Circle which of the following run in your family: Please Specify:

- Cancer or benign tumors _____
- Hearing loss _____
- Allergies or asthma _____
- Bleeding or clotting disorders _____
- Heart or lung problems _____
- Diabetes, thyroid, endocrine problems _____
- Lupus, multiple sclerosis, autoimmune _____
- Neurologic or genetic conditions _____

Social History

Occupation / what you do for work: _____

Who do you live with? _____

Tobacco /smoking: never previous, when did you quit? _____ Yes, how Often? _____

Alcohol consumption: daily 1-4 times /week less than 1 time /week never

Recreational drugs: heroin or opiods cocaine marijuana other _____

Medications: *(Include dosage, frequency and list all herbal, over-the-counter, & topical treatments)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

Drug Allergies: List drug and reaction: None known

**SPOKANE VALLEY EAR, NOSE & THROAT AND FACIAL PLASTICS
SYSTEM REVIEW**

Please circle if you have ever had any of the following:

Constitutional Symptoms

Recent Headaches..... No Yes
 Recent weight change..... No Yes
 Recent Fever..... No Yes
 Recent Fatigue..... No Yes

Eyes

Eye disease or injury..... No Yes
 Wear glasses/contacts..... No Yes
 Blurred/double vision..... No Yes
 Glaucoma..... No Yes

Ears/Nose/Mouth/Throat

Hearing Loss/ ringing..... No Yes
 Earaches or drainage..... No Yes
 Chronic sinus problems..... No Yes
 Nose bleeds..... No Yes
 Mouth sores..... No Yes
 Bleeding gums..... No Yes
 Bad breath or taste..... No Yes
 Sore throat/voice change..... No Yes
 Swollen glands in neck..... No Yes

Cardiovascular

Heart trouble/Disease..... No Yes
 Chest pain..... No Yes
 Palpitations..... No Yes
 Shortness of breath..... No Yes
 Swelling of feet/ankles..... No Yes
 High blood pressure..... No Yes

Respiratory

Chronic/frequent cough..... No Yes
 Spitting up blood No Yes
 Asthma..... No Yes
 Wheezing..... No Yes
 Sleep Apnea..... No Yes

Gastrointestinal

Loss of appetite..... No Yes
 Nausea/vomiting..... No Yes
 Rectal bleeding..... No Yes
 Abdominal pain..... No Yes
 Ulcer..... No Yes

Psychiatric

Nervousness..... No Yes
 Depression..... No Yes
 Insomnia..... No Yes

Cancer/Other _____

Signature _____

Patient/Guardian

Genitourinary

Frequent Urination..... No Yes
 Incontinence..... No Yes
 Blood In urine..... No Yes

Musculoskeletal

Joint pain..... No Yes
 Weakness of muscles..... No Yes
 Muscle pain/cramps..... No Yes
 Difficulty Walking..... No Yes
 Arthritis..... No Yes

Neurological

Frequent Headaches..... No Yes
 Recurring headaches..... No Yes
 Seizures/Convulsions..... No Yes
 Numbness/Tingling..... No Yes
 Tremors..... No Yes
 Paralysis..... No Yes
 Stroke..... No Yes
 Head Injury..... No Yes
 Memory loss..... No Yes

Endocrine

Glandular/hormone..... No Yes
 Thyroid disease..... No Yes
 Diabetes..... No Yes
 Excessive thirst..... No Yes
 Heat/cold intolerance..... No Yes

Hematologic/Lymphatic

Slow to heal..... No Yes
 Easy bruising/bleeding..... No Yes
 Anemia..... No Yes
 Hepatitis..... No Yes
 HIV..... No Yes

Allergic/immunologic – Have you ever had a bad reaction to any of the following:

Antibiotics..... No Yes
 Penicillin..... No Yes
 Morphine/Demerol/Codeine..... No Yes
 Aspirin..... No Yes
 Tetanus or other serum..... No Yes
 Iodine..... No Yes
 Shell fish..... No Yes
 Narcotics..... No Yes
 Anesthesia..... No Yes
 Acute Infections..... No Yes
 Latex..... No Yes
 Other _____