ADULT HEALTH HISTORY

PLEASE PRINT CLEARLY

LAKESHORE
EAR, NOSE, THROAT CENTER, PC

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

Name: _____ Height: _____ Weight: _____

Preferred Phone Number: (_____)_____ Email: _____

Primary Care Physician: _____

Other practitioners needing letters (First & Last Name): _____

Did a physician refer you to Lakeshore ENT? ☐ Yes ☐ No If "Yes," which physician: _____

Where does your physician send you for testing? _____

Preferred Pharmacy (name and phone number): _____

MAIN REASON FOR VISIT TODAY:

What is the primary reason for today's visit? _____

ALLERGIES: ☐ None *(If "None" please skip to the next section)*

List medication allergies and reactions: _____

MEDICATIONS: List attached: ☐ Yes *(If "Yes" please skip to the next section)*

Do you use any of the following? *(please **circle**)* Aspirin Motrin/Ibuprofen Blood Thinners Vitamin E

List all current medications below, including dose and frequency (attach sheet if necessary):_____

_____

_____

MEDICAL HISTORY: *(please **check** all that apply)*

☐Allergic Rhinitis	☐Cancer (what area of body?)		☐Migraines
☐Anesthesia Problems	☐Bleeding Disorders	☐Hearing Loss	☐Reflux (GERD)
☐Asthma	☐COPD (lung disease)	☐Hepatitis	☐Stroke
☐Anxiety	☐Diabetes	☐High Blood Pressure	☐Thyroid Disease
☐Autoimmune Disorder	☐Fibromyalgia	☐High Cholesterol	☐Vascular Disease
☐Blood Clots	☐Heart Disease	☐Kidney Disease	☐Vision Problems

MAJOR SURGERIES: *(please **check** all that apply)*

☐Adenoid Surgery	☐Cleft Lip and/or Palate	☐Heart Defibrillator	☐Rhinoplasty
☐Back Surgery	☐Dental/Oral Surgery	☐Larynx/Vocal Cord Surgery	
☐Bariatric Surgery	☐Eardrum Tympanoplasty	☐Mastoid Surgery	☐Septoplasty
☐Cancer Surgery	☐Ear Tube Placement	☐Neck Dissection	☐Sinus Surgery
☐Carotid Artery Surgery	☐EGD/Esophagoscopy	☐Neuro(Brain) Surgery	☐Thyroid Surgery
☐Cervical Spine Surgery	☐Heart Surgery(Bypass)	☐Parotidectomy	☐Tonsil Surgery

FAMILY MEDICAL HISTORY: *(please **check** all that apply)*

☐Asthma	☐Cancer	☐Heart Disease
☐Bleeding Disorders	☐Hearing Loss	☐Thyroid Disease

SOCIAL HISTORY: (*please **check** all that apply*)

Tobacco products (including marijuana) ☐ Yes ☐ No Number of years: ____ Packs/day: ____ Year you quit: ____
What is your occupation? _____ Are you retired? ☐Yes ☐No
Alcohol: ☐ Yes ☐ No Daily amount: _____ How many years? _____Year you quit: _____
Do you use illicit drugs? ☐ Yes ☐ No If yes, what drugs? _____
Are you hard of hearing or deaf in one or both ears? ☐ Yes ☐ No
Any special religious, spiritual, or cultural needs we need to be aware of? ☐ Yes ☐ No

Patient/Guardian Signature: _____