Northland Ear, Nose & Throat, P.C.
Adult Medical History Form
www.northlandent.com

_____
Today's Date

Legal Name: _____ Current Age: _____ Date of Birth: _____
☐ Male ☐ Female Height : _____ Weight: _____
Family Physician: _____ Referring Physician: _____

Reason for being seen today (Please list your symptoms): _____
_____
_____

Onset of symptoms: _____

How severe are your symptoms at this time:
☐ No longer present
☐ Mild
☐ Moderate
☐ Severe
☐ Disabling

List the medications used to treat your symptoms:
(Include non-prescriptions)_____
_____
_____
_____
_____

Current Medications (Including Non-Prescriptions):

Medication:	Dose:	How often do you take the medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History:
Do you have a history of

☐	Heart Disease	☐	Pneumonia		
☐	Myocardial Infarction (heart attack)	☐	Chronic bronchitis or emphysema		
☐	Heart rhythm problems	☐	Kidney disease		
☐	Hypertension (High blood pressure)	☐	Other urinary tract disease		
☐	Bleeding disorders	☐	Hepatitis or liver disease		
☐	Stroke	☐	AIDS or HIV positive status		
☐	High cholesterol	☐	Spine problems		
☐	Cancer (please list below)	☐	Arthritis		
☐	Diabetes	☐	Depression	☐	Other major illnesses (list)

Comments: _____
_____

Past Surgeries or Trauma History:
Please mark any prior surgeries and the date completed next to it.

☐	Tonsillectomy/Adenoidectomy	☐	Coronary artery bypass grafting		
☐	Ear or mastoid surgery	☐	Coronary artery stenting		
☐	Nasal or sinus surgery	☐	Lung surgery	☐	Excessive Bleeding
☐	Removal of lymph nodes from neck	☐	Cholecystectomy (Gall Bladder)		
☐	Thyroid gland surgery	☐	Appendectomy	☐	Anesthesia Difficulties
☐	Other head or neck surgery	☐	Spine surgery		
☐	Orthopedic surgery	☐	Gynecological procedures		

☐ Other (please list) _____
_____

CONTINUED ON BACK SIDE

Family Medical History:
Is there a family history of heart disease, stroke, cancer, hearing loss, diabetes, thyroid, etc? Please list details:
_____
_____
_____

Allergy History/Drug Allergies:
_____
_____
_____

Tobacco Use:

☐ None	☐ Previous	☐ Current
☐ Cigarettes		Date Started: _____
☐ Pipe		Date Stopped: _____
☐ Cigars		Amount used daily: _____
☐ Chewing Tobacco		
☐ Snuff		

Beverage Consumption:

☐ None	☐ Previous	☐ Current
☐ Beer		Date Started: _____
☐ Hard Liquor		Date Stopped: _____
☐ Wine		Amount used daily: _____
☐ Coffee/Tea		
☐ Soda/Pop		

Systems Review:
Please check all that apply to you:
Sleep: ☐ none ☐ loud snoring ☐ excessive daytime sleep ☐ trouble going to sleep ☐ trouble staying asleep

Constitutional: ☐ fever ☐ chills ☐ excessive weight loss or gain ☐ fatigue

Eyes: ☐ vision loss ☐ double vision ☐ tearing eyes ☐ worsening vision

Cardiovascular: ☐ palpitations ☐ racing heart ☐ chest pains ☐ cold/swollen extremities

Respiratory: ☐ wheezing ☐ dry cough ☐ productive cough ☐ night sweats ☐ shortness of breath

Gastrointestinal: ☐ increased/decreased appetite ☐ nausea ☐ vomiting ☐ abdominal pain ☐ diarrhea/constipation

Musculoskeletal: ☐ joint pain ☐ swelling ☐ stiffness ☐ muscle weakness

Integumentary: ☐ changes in skin lesion

Psychiatric: ☐ irritability ☐ depression ☐ anxiety ☐ insomnia ☐ drug or alcohol addiction (past or present)

Neurological: ☐ loss of smell or taste ☐ facial weakness or numbness ☐ memory problems ☐ headaches (how often)
☐ difficulty walking ☐ difficulty swallowing/speaking

Endocrine: ☐ increase in size of hands/feet ☐ heat/cold intolerance ☐ excessive thirst ☐ thyroid problems

Hematologic/Lymphatic: ☐ swollen nodes ☐ excessive bruising or bleeding

Allergic/Immunologic: ☐ allergy to medicines ☐ seasonal allergies

Additional: _____
_____

_____ _____
Patient Signature **Date**