Century Ear, Nose and Throat
Head and Neck Surgery

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GENERAL HISTORY

Patient Name: ____

DOB: ______________________ Sex: ______ If under 18, Guarantor: ______________________

Patient Address: ____

City: ______________________________ State: ____________ Zip: ______________

Home Phone: ________________ Cell Phone: ________________ Work Phone: ________________

Social Security No. (last 4 digits) ______________________ Ht. __________ Wt. __________

Race: ____________________ Language: ____________________ Ethnicity: ____________________

E-mail address: ____

Primary Care Physician: ________________________ Phone No.: ____________________

Referring Physician: ________________________ Phone No.: ____________________

Pharmacy Name: ______________________ Pharmacy Location: ______________________

Emergency Contact:______________________________Phone:______________________

MEDICATION ALLERGIES: ______________________________ No known drug allergies ______

List any DRUG reactions and side effects experienced (e.g., shortness of breath, swelling, itching, hives, nausea, vomiting, diarrhea): ____

____

List all **MEDICATIONS** you are taking or attach list (prescription and over-the-counter). None ______

Medication	Dosage	How often taken

FAMILY HISTORY Please check all that apply.

Bleeding disorder ______
Anesthesia reaction ______
Heart disease ______
High cholesterol ______
Environmental allergies ______
High blood pressure ______

Hearing loss ______
Diabetes ______
Asthma ______
Seizures ______
CVA (stroke) ______
Cancer ______ Type: ______________________

Other: ____

MEDICAL HISTORY Have you been diagnosed with any of the following? Please check all that apply.

Anemia ______
Anesthesia reaction ______
Asthma/COPD ______
Auto-immune disorder ______
Bleeding disorder ______
Cancer ______
Type: ____________________________
CVA (stroke) ______
Diabetes ______
Environmental allergies ______
Gastroesophageal reflux ______
Heart disease ______
Hepatitis ______
High cholesterol ______
High blood pressure ______
HIV or AIDS ______
Joint replacement ______
Kidney disease ______
Liver disease ______
Pacemaker/defibrillator ______
Sickle cell disease ______
Sleep apnea ______
Seizures ______
Thyroid disease ______
Tuberculosis _______

No medical history ______ Other: ____

SURGICAL HISTORY Please check any EAR, NOSE or THROAT surgeries.

EAR
Ear tubes ______
Tympanoplasty (ear drum) ______
Mastoidectomy (mastoid) ______

NOSE
Septoplasty (deviated septum) ______
Rhinoplasty (nose reconstruction) ______
Turbinate reduction ______
Nasal polyp removal ______
Nasal fracture repair ______

SINUS
Balloon sinuplasty ______
Traditional sinus surgery ______

THROAT
Tonsillectomy ______
Adenoidectomy ______
Tracheostomy ______
Excision of neck mass ______
Tonsil/palate surgery ______
Laryngoscopy ______
Larynx (voice box) ______
Thyroid ______
Cleft lip/palate ______

Other: ____

SOCIAL HISTORY Please check all that apply.

Tobacco use? Yes ______ No ______ Former ______
Exposed to secondhand smoke? Yes ______ No ______
Alcohol consumption? Occasional ______ Often ______ None ______
Recreational drug use? Yes ______ No ______

PEDIATRIC HISTORY Complete if patient is under 18.

Was patient born premature? Yes ______ No ______ If yes, number of weeks premature ______
Require intubation or oxygen after delivery? Yes ______ No ______
Was child breastfed? Yes ______ No ______ If yes, for how long _________________
Has your child had any feeding/dietary problems? Yes ______ No ______
Any difficulties with growth or weight gain? Yes ______ No ______
Does child have noisy breathing? Yes ______ No ______
Has your child had any of the following delays? Walking ______ Learning ______ Talking ______
Does child live with: Mother ______ Father ______ Both Parents ______
Other: ____
Are immunizations current? Yes ______ No ______

FEMALES ONLY

Chance of pregnancy? Yes ______ No ______
Currently breastfeeding? Yes ______ No ______