

COLORADO WEST OTOLARYNGOLOGISTS, P.C.

425 Patterson, Suite 503 ♦ Grand Junction, CO 81506

****Please print using black ink****

Confidential Record: Information contained herein will not be released except when you have authorized us to do so.

Patient Medical History Form Referring Doctor _____ Date _____

Name _____ DOB _____

Reason For Visit _____

When did problem first appear? _____ Please list name and approximate date of previous treatment for this problem from other practitioners _____

Ear Nose and Throat Questions Please Check all that apply to **You**

- | | |
|--|--|
| <input type="checkbox"/> Sore spot or abnormal bump in mouth or throat | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Sensation of a lump in your throat | <input type="checkbox"/> Ear Pain |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Ear Drainage |
| <input type="checkbox"/> Pain on swallowing | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Obstructed breathing through nose | <input type="checkbox"/> Blind Spots |
| <input type="checkbox"/> Draining Sinus | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Mouth or Throat bleeding | <input type="checkbox"/> Wear glasses |
| <input type="checkbox"/> Recurrent Sinusitis | <input type="checkbox"/> Wear contacts |

Comments: _____

General Health Questions Please Check all that apply to **You**

- | | |
|---|--|
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Trouble opening mouth |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Limited joint motion |
| <input type="checkbox"/> Constant cough | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Have you ever had any Neurological problem? |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Irregular heart beat/Palpitations | <input type="checkbox"/> Numbness/Weakness |
| <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart burn/Acid Reflux (requiring frequent antacids) | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Other Mental Problems |
| <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sickle cell disease/trait |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Easily bruised |
| <input type="checkbox"/> Hiatal hernia | |

Comments: _____

Please circle Drug Allergies Penicillin Sulfa Codeine Latex Iodine None Known
Other (please list) _____

Children (18 and under)

Immunizations current & up to date? ____ Yes ____ No History of chicken pox? ____ Yes ____ No
Chicken pox vaccine? ____ Yes ____ No

Family History Has a blood relative had:

- Reaction to anesthesia
- Bleeding problems
- Heart disease
- Diabetes
- Cancer

Medical Illnesses Please Check all that apply to **You**

- Cancer - what part of the body? _____ approximate date of diagnosis? _____
- Tuberculosis
- Asthma
- Emphysema
- Diabetes
- Heart troubles
 - Heart Attack
 - Rheumatic Fever
 - Congestive Heart Failure
 - Atrial Fibrillation
- High Blood pressure
- High cholesterol/triglycerides
- Stroke
- Epilepsy/Seizures
- Ulcers
- Thyroid disorder _____
 - Hyperthyroid
 - Hypothyroid
- Bleeding problems
- Kidney Stones
- Hepatitis – Type _____
 - Active
 - Inactive
- HIV/AIDS

Surgeries/Hospitalizations:

Please list the name and approximate date of **ALL** previous surgical procedures and serious hospitalizations.(not just ENT related)

Name of Operation	Date	Name of Operation	Date

Have **You** ever had a serious reaction to anesthesia? Yes No If yes, describe _____

Are You Pregnant? Yes No N/A

Have **You** ever had a blood transfusion? Yes No When? _____

Social History

Marital Status S M D W Do you have children Yes No (Ages)_____

Profession _____

Place an "X" in proper Column Yes No

	Yes	No		
Do you or have you chewed tobacco?			How long?	Date quit -
Do you or have you ever smoked cigarettes ___ or marijuana ___?			How long?	Date quit -
			How many packs a day?	
Do you drink alcohol?			How much per week?	
Do you or have you ever used cocaine or IV drugs?			How often?	

Please list ALL medications you are now taking (or attach list if extensive) Please write none if you are not taking any medications

Name	Strength(mg)	Times per day	Name	Strength(mg)	Times per day

Please list your pharmacy of choice for prescriptions. _____