northwest ENT associates

**Patient Name:** ________________________ **Date of Birth:** ________ Ht: ______ Wt: ____

**Past Medical History (patient):** (please check all that apply)

| | | | | |
|---|---|---|---|---|
| o Actinic Keratosis | o Blood clots | o GERD | o Hyperthyroidism | o Psoriasis |
| o Allergies | o Cancers _______ | o Glaucoma | o Hypothyroidism | o Rosacea |
| o Anemia | o Chronic infection | o Graves Disease | o Irregular heart rate | o Seizure disorder |
| o Anxiety | o COPD | o Headaches | o Kidney disorder | o Sleep Apnea |
| o Arthritis | o CVA (stroke) | o Heart disease/CAD | o Liver Disease | o Thyroid disease |
| o Asthma | o Depression | o Hepatitis C | o Mental disorder | o Tinnitus |
| o Atrial Fibrillation | o Diabetes | o High cholesterol | o Multiple Sclerosis | o Tuberculosis |
| o Bleeding disorder | o Eczema | o Hypertension | o Otosclerosis | o Vertigo |

Do you have history of skin cancer? YES NO

---

**Past Surgical History:** (please list with date)

---

**Social History:**

Do you smoke cigarettes? o Current o Never o In the past #packs/day_______ #years___________

Do you use recreational drugs? o Yes o No Type:____________________

Do you drink alcohol? o Yes o No # drinks/week_____________

Do you drink caffeine? o Yes o No # drinks/day______________

Are you currently pregnant? o Yes o No

Are you currently breast feeding? o Yes o No

Recent changes in your sleep pattern? o Yes o No

Marital Status: o Single o Married o Divorced o Separated o Widowed o Partnered

Do you have children? o Yes o No

Occupation:

---

**Family History:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Abnormal moles | o No | o Yes | relative:_________ | Hepatitis | o No | o Yes | relative:_________ |
| Allergies | o No | o Yes | relative:_________ | High Cholesterol | o No | o Yes | relative:_________ |
| Asthma | o No | o Yes | relative:_________ | Hypertension | o No | o Yes | relative:_________ |
| Autoimmune disease | o No | o Yes | relative:_________ | Keloids | o No | o Yes | relative:_________ |
| Cancer | o No | o Yes | relative:_________ | Migraines | o No | o Yes | relative:_________ |
| COPD | o No | o Yes | relative:_________ | Otitis Media- chronic | o No | o Yes | relative:_________ |
| Depression | o No | o Yes | relative:_________ | Otosclerosis | o No | o Yes | relative:_________ |
| Dermatitis | o No | o Yes | relative:_________ | Psoriasis | o No | o Yes | relative:_________ |
| Diabetes | o No | o Yes | relative:_________ | Rosacea | o No | o Yes | relative:_________ |
| Eczema | o No | o Yes | relative:_________ | Seizure disorder | o No | o Yes | relative:_________ |
| Hearing disorder | o No | o Yes | relative:_________ | Thyroid disease | o No | o Yes | relative:_________ |

Family history of skin cancer? YES NO

---

**Medications:** Do you take any prescription/non-prescription medications or supplements? **o No** **o Yes** (please list)

---

**Allergies:** Do you have any allergies or sensitivities to medications that you know of? **o No** **o Yes** (please list)

---

**Patient Signature:**__________________________________________ **Date:**__________________