DEMERA
ALLERGY ASTHMA & ENT CENTER

EAR, NOSE AND THROAT MEDICAL HISTORY

Patient Name: _____ DOB: _____ Date: _____

Age: _____ Sex: _____ Ht: _____ Wt: _____ BMI: _____

Primary Physician _____ Referring Physician: _____

Reason for Visit: _____

GENERAL EAR, NOSE AND THROAT QUESTIONS:

Do you have a history of surgery to the ear(s), nose, mouth, throat, or neck? ☐YES ☐NO

If so, what type and when? _____

Do you have hearing loss? ☐YES ☐NO

If so, how long? When was your last hearing test? _____

Do you wear hearing aids? ☐YES ☐NO

If so, how long? When were they purchased? _____

Do you experience ringing of the ears? ☐YES ☐NO

If so, how long? Describe the sound: _____

Do you have problems with vertigo? ☐YES ☐NO

If so, how long? Studies? _____

Do you have a history of GERD? ☐YES ☐NO

If so, diagnosis made when? Tests performed? _____

Do you have a change in voice? ☐YES ☐NO

Do you have trouble or pain with your voice or with swallowing? ☐YES ☐NO

Do you drink alcoholic beverages? ☐YES ☐NO

If so, how frequently? How much? _____

Do you smoke? ☐YES ☐NO

If so, what do you smoke? How often? _____

Do you snore or have sleep apnea? ☐YES ☐NO

If so, are you on CPAP? ☐YES ☐NO

Do you fall asleep easily (or too easily)? ☐YES ☐NO

Do you breathe normally through your nose? ☐YES ☐NO

Medical History (check box if applicable and explain):

☐ Allergies ☐ Sinus Problems ☐ Recurrent Facial Pain ☐ Thyroid Disease, Nodules, or Masses

☐ Masses / Cancers of the ear, nose, oral cavity, throat, head or neck ☐ Recurrent wax impaction / Mastoid bowl hygiene

Other / Explain: _____

_____

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