



A caring approach to treatment of the ears, nose, throat, head, and neck for children and adults

PATIENT HISTORY

PAIGE POWERS, M.D.

Today's Date	
Patient Name	
Date of Birth	Age

CURRENT CONCERN

Referring Physician / Person	Primary Physician
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Describe the **main reason for this visit** / concerns you wish to speak with the doctor about (Please be as specific / detailed as possible)

PERSONAL HISTORY

Do you have or have you ever had any of the following health problems? (check / circle all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sinus / Allergies | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis Type _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Glaucoma / Eye Disease | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Bleeding Problems / Anemia | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Acid Reflux / Heartburn | <input type="checkbox"/> Cancer _____ | |
| <input type="checkbox"/> Stroke / aneurysm | <input type="checkbox"/> Crohn's / Ulcerative Colitis | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression / Anxiety / Stress | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Hyperthyroid / Hypothyroid | | <input type="checkbox"/> Other _____ | |

List any **medications** including herbs, vitamins, birth control, aspirin, that you take on a regular basis (specify dosage):

Medications you are **allergic** to:

List any Prior surgery or hospitalizations with dates:

Have any labs / X-rays / CT's / MRI's been obtained relative to your current problem? yes no
Where / when?

FAMILY HISTORY

List any medical problems in **your family** (high blood pressure, heart disease, diabetes, allergies, asthma, etc.):

Any bleeding disorders in your family? yes no

Anesthesia complications in your family? yes no

SOCIAL HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Smoker: _____ pack / day, for _____ years | <input type="checkbox"/> Quit in _____ (year) |
| <input type="checkbox"/> Nonsmoker _____ | <input type="checkbox"/> Smokeless Tobacco _____ |
| <input type="checkbox"/> Alcohol use: _____ drinks / week <input type="checkbox"/> No alcohol use | <input type="checkbox"/> Caffeine: _____ / day |
| <input type="checkbox"/> Environmental exposures: _____ smokers _____ pets _____ pollutants | |