



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

# PATIENT HISTORY

Today's Date	
Patient Name	
Date of Birth	Age

PAIGE POWERS, M.D.

## CURRENT CONCERN

Referring Physician	City / Location of Referring 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 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"/> Heart Disease       | <input type="checkbox"/> Glaucoma / Eye Disease     | <input type="checkbox"/> Asthma, Lung Disease,<br>Persistent Cough |                                     |
| <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Cancer _____                              |                                     |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Bleeding Problems / Anemia | <input type="checkbox"/> Other _____                               |                                     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Acid Reflux / Heartburn    | <input type="checkbox"/> Other _____                               |                                     |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression / Anxiety       |  |                                     |

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, etc.):

Any bleeding disorders in your family?  yes  no

Anesthesia complications in your family?  yes  no

## SOCIAL HISTORY

- |                                     |  |   |
|-------------------------------------|--|---|
| Have you ever smoked cigarettes?    | <input type="checkbox"/> yes <input type="checkbox"/> no | How Long? _____ Packs per day _____   |
| Do you still smoke?                 | <input type="checkbox"/> yes <input type="checkbox"/> no | When did you stop smoking? _____  |
| Are you exposed to cigarette smoke? | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe                                   |
| Do you chew tobacco?                | <input type="checkbox"/> yes <input type="checkbox"/> no | If so, how long did you chew tobacco? _____   |
| Do you drink alcohol?               | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> occasional <input type="checkbox"/> never |