Pappas Ear Clinic

Patient Health History

Name ____ Age ____

Chief Complaint ____

Duration ____

Past History

- [ ] alcoholism
- [ ] alzheimer's
- [ ] arthritis
- [ ] asthma
- [ ] anemia
- [ ] autoimmune disease
- [ ] back problems
- [ ] cancer
- [ ] cleft lip
- [ ] cleft palate
- [ ] cleft palate and lip
- [ ] defibrillator
- [ ] depression
- [ ] diabetes insulin
- [ ] diabetes noninsulin
- [ ] Down syndrome
- [ ] emphysema
- [ ] fibromyalgia
- [ ] glaucoma
- [ ] gout
- [ ] heart disease
- [ ] heart attack
- [ ] heart murmur
- [ ] hemophilia
- [ ] hepatitis
- [ ] hepatitis A
- [ ] hepatitis B
- [ ] hepatitis C
- [ ] HIV/AIDS
- [ ] hypertension
- [ ] liver disease
- [ ] migraine headaches
- [ ] MVP mitral valve prolapse
- [ ] myasthenia gravis
- [ ] pacemaker
- [ ] peptic ulcer disease
- [ ] prostate disease
- [ ] reflux
- [ ] renal stones
- [ ] rheumatic fever
- [ ] seizure disorder
- [ ] sickle cell disease
- [ ] sickle cell trait
- [ ] sleep apnea with CPAP
- [ ] sleep apnea
- [ ] stroke
- [ ] stroke (mini)
- [ ] thyroid disease
- [ ] tuberculosis
- [ ] malignant hypothermia
- [ ] pregnancy (current)
- [ ] renal failure
- [ ] multiple sclerosis
- [ ] no medical issues

Cancer Type: ____

Additional Past History: ____

Prior Surgery

- [ ] none
- [ ] ear tubes
- [ ] ear surgery
- [ ] cardiac
- [ ] cardiac stents
- [ ] tonsillectomy
- [ ] adenoidectomy
- [ ] appendectomy
- [ ] gallbladder
- [ ] hysterectomy
- [ ] hernia repair
- [ ] back surgery
- [ ] oral surgery
- [ ] sinus surgery
- [ ] brain surgery
- [ ] cancer surgery
- [ ] plastic surgery

Additional Prior Surgery: ____

Birth History (children only)

- [ ] Normal Birth
- [ ] Abnormal Birth
- [ ] Premature Birth
- [ ] Complicated Delivery
- [ ] Complicated Pregnancy
- [ ] Low APGAR
- [ ] Ventilator
- [ ] ICU
- [ ] Elev Bilirubin

MD sign: ____ ____ ____
____ ____ ____

Family History
- ☐ hearing loss
- ☐ severe anesthesia reactions
- ☐ asthma
- ☐ autoimmune disease
- ☐ bleeding disorder
- ☐ brain tumors
- ☐ cancer
- ☐ diabetes
- ☐ heart disease
- ☐ hypertension
- ☐ stroke

Additional Family History:

Social History ☐ married ☐ single ☐ widowed ☐ disabled ☐ student

Smoking History ☐ nonsmoker ☐ social smoker ☐ chews tobacco ☐ smoker ☐ quit smoking ☐ vaping

Packs per day ☐ <1 ☐ 1 ☐ 1-2 ☐ 2 ☐ 2-3 ☐ 3 or more

smoking years ______ years quit ______

Alcohol ☐ yes ☐ no ☐ quit drinks per day ______ or drinks per week ______

Occupational Status ☐ employed ☐ unemployed ☐ housewife/husband ☐ disabled ☐ studen

Occupation:

Medications	Dose	Frequency	Medications	Dose	Frequency

Allergies
- ☐ Penicillins
- ☐ Sulfa
- ☐ Cephalosporins
- ☐ Cipro
- ☐ Levaquin
- ☐ Erythromycin
- ☐ Aminoglycocides
- ☐ Codeine
- ☐ Morphine
- ☐ Demerol
- ☐ Caine Drugs
- ☐ Aspirin
- ☐ Iodine
- ☐ Anesthesia meds
- ☐ None
- ☐ Other: ______________
- ☐ Other: ______________
- ☐ Other: ______________
- ☐ Other: ______________

MD sign: ______________ ______________ ______________

______________ ______________ ______________

(Please check yes or no for each item)

Cardiovascular:

	yes	no
irregular pulse	___	___
palpitations	___	___
chest pain	___	___
valve disease	___	___
left arm pain	___	___

Respiratory:

	yes	no
bronchitis	___	___
pneumonia	___	___
chronic cough	___	___
shortness of breath	___	___
bloody sputum	___	___

Eyes:

	yes	no
loss of vision	___	___
dryness	___	___
cataracts	___	___
eye infections	___	___
eye injuries	___	___

Genitourinary:

	yes	no
blood in urine	___	___
incontinence	___	___
urinary infections	___	___
difficult / painful urine	___	___

Endocrine:

	yes	no
hormone problems	___	___
excessive thirst	___	___
excessive urination	___	___
increased appetite	___	___
change glove/shoe size	___	___

Hematologic (blood):

	yes	no
anemia	___	___
prior transfusion	___	___
bleeding tendency	___	___
enlarged glands	___	___

Immunologic:

	yes	no
nasal allergies	___	___
food allergies	___	___
autoimmune disorder	___	___

ENT:

	yes	no
nosebleeds	___	___
sore throats	___	___
hoarseness	___	___
difficult swallowing	___	___
nasal congestion/drainage	___	___

Gastrointestinal:

	yes	no
stomach pain	___	___
nausea / vomiting	___	___
diarrhea	___	___
hemorrhoids	___	___
liver disease	___	___

Neurologic:

	yes	no
headaches	___	___
seizures	___	___
fainting spells	___	___
double vision	___	___
memory difficulties	___	___

Skin:

	yes	no
rash	___	___
chronic itching	___	___
nail changes	___	___
breast lump / discharge	___	___

Musculoskeletal:

	yes	no
muscle weakness	___	___
joint pain	___	___
back pain	___	___
recent broken bones	___	___

Constitutional:

	yes	no
fever / chills	___	___
night sweats	___	___
fatigue	___	___
unexpected weight change	___	___

Psychiatric:

	yes	no
depression	___	___
anxiety attacks	___	___
memory loss / confusion	___	___

MD sign: ____________________ ____________________ ____________________

____________________ ____________________ ____________________

Pharmacy Information

Patient Name: ____

Date Birth: ______________________________

The following information is needed for any prescriptions that may be written by the Pappas Ear Clinic, P.C.

Pharmacy Name: ____

Street Address: ____

City, State, Zip: ____

Pharmacy Phone Number: (_______)________________________________