EASTERN SHORE
ENT & Allergy
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PAST MEDICAL HISTORY

_____ / _____ / _____
(Today's Date)

Patient Name _____

D.O.B. _____ S.S.N. _____

Acid reflux	Yes	No	Cataracts	Yes	No	Emphysema	Yes	No
Hyperthyroidism	Yes	No	Melanoma	Yes	No	Sarcoidosis	Yes	No
Heart disease	Yes	No	Thyroid nodule	Yes	No	End-stage renal disease	Yes	No
Heart attack	Yes	No	Congestive heart failure	Yes	No	Stroke	Yes	No
Hypothyroidism	Yes	No	Mitral valve prolapse	Yes	No	Austim or other		
Depression	Yes	No	High cholesterol	Yes	No	developmental disorder	Yes	No
Sleep apnea	Yes	No	COPD	Yes	No			
Kidney disease	Yes	No	Multinodular goiter	Yes	No	Type of Cancer _____		
Asthma	Yes	No	Hepatitis	Yes	No	_____		
Atrial fibrillation	Yes	No	Deep vein thrombosis	Yes	No			
Lyme disease	Yes	No	Organ transplant	Yes	No	Grave's disease	Yes	No
Lupus	Yes	No	High blood pressure	Yes	No	Bleeding disorder	Yes	No
Carotid stenosis	Yes	No	Diabetes	Yes	No			
Malignant hyperthermia	Yes	No	Pulmonary embolism	Yes	No	Other _____		
Epilepsy	Yes	No	Cancer	Yes	No			

Do you have a pacemaker?	Yes	No	Do you have any metal clips, stents plates, or rods?	Yes	No
Do you have a defibrillator?	Yes	No	Are you claustrophobic?	Yes	No
Do you use a CPAP or BiPAP machine?	Yes	No	Any recent blood work done?	Yes	No

Drug Allergies, including contrast dye: (If yes, list specific reaction) _____

_____

Past Surgeries or Hospitalizations _____

_____

Past Family History: (If yes, specify relationship)

Allergies _____	Hearing loss _____	Malignant hyperthermia _____
Cancer _____	Heart disease _____	Stroke _____
Diabetes _____	Hypertension _____	Other _____

SMOKING *(Please check box)*

Are you? ☐ Current Smoker ☐ Former Smoker ☐ Nonsmoker

How often do you smoke? ☐ Every Day ☐ Some Days

How many cigarettes/cigars do you smoke a day? ☐ <Five ☐ Six to 10 ☐ 11–20 ☐ 21–30 ☐ >31

How soon after you wake up do you smoke? ☐ Five min ☐ Six to 30 min ☐ 31–60 min ☐ >60 min

Are you interested in quitting? ☐ Yes ☐ No

ALCOHOL USE *(Please check box)*

Did you drink alcohol in the past year? ☐ Yes ☐ No

How often do you drink alcohol? ☐ Never ☐ Monthly ☐ Two to Four Times per Month
☐ Two to Three Times per Week ☐ >Four Times per Week

When you drink alcohol, how much do you typically drink? ☐ One to Two Drinks ☐ Three to Four Drinks
☐ Five to Six Drinks ☐ Seven to Nine Drinks ☐ >10 Drinks

How often do you have more than six drinks on one occasion? ☐ Never ☐ <Monthly ☐ Monthly ☐ Weekly ☐ Daily

Do you have any religious beliefs that prohibit medical treatment? ☐ Yes ☐ No
If yes, please explain. _____

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