S. C. E. N. T. A

Space Coast Ear Nose & Throat, Associates

MEDICAL HISTORY

NAME: _____ Primary Care Doctor: _____

Reason for today's visit:

_____

Please indicate, with check or x, if you have, or have been treated, for any of the following conditions:

Auto-immune disorder:		Bleeding /clotting disorder:		Cancer, Type:	
Allergies		Hepatitis C		Chemo / Radiation	
Asthma		HIV/AIDS		Snoring	
COPD		High Blood Pressure		Substance Abuse	
Diabetes		High cholesterol		Stroke	
Depression / Anxiety		Kidney disease		Sinusitis	
Headaches		Meniere's Disease		Sleep Apnea - If yes, C - Pap or Bi- Pap	
Heart Disease		Mental Illness		Thyroid Disorder	
Heartburn/ Acid Reflux		Liver Disease		Chronic pain disorder	
Hearing Loss		Organ Transplant:		Vertigo	

Any other conditions:

_____

CURRENT MEDICATIONS: *Please include any over the counter and/or supplements.*

_____ _____

_____ _____

_____ _____

_____ _____**OVER->**

Are you allergic to any drugs or foods? YES / NO

Please list: _____

Please list any surgeries you have had, and the approximate year done:

_____ _____

_____ _____

_____ _____

Have you been admitted into the hospital for an illness or injury? Yes / No

If yes, please indicate condition and approximate year:

_____ _____

_____ _____

Are you currently under the care of a specialist in the following fields?

Cardiologist YES / NO Past history of being treated? Yes / NO

Pulmonologist YES / NO Past history of being treated? Yes / NO

Neurologist YES / NO Past history of being treated? Yes / NO

Pain Management YES / NO Past history of being treated? Yes / NO

If yes, who is your doctor? _____

Currently receiving any type of medical therapy in home or outpatient?

If yes what kind? Physical / Speech / Occupational/ Swallowing/ Respiratory

With what agency? _____

For patients being seen for snoring or sleep apnea related issues:

EPWORTH SLEEPINESS SCALE: _____/ 24

0= No change of dozing 1= slight chance of dozing 2= Moderate chance 3= High chance of dozing

_____Sitting and reading _____Lying down to rest in the afternoon ____In a stopped car in traffic

_____As a passenger in car more than 1 hour w/o break ____Sitting quietly after lunch w/o alcohol

_____Sitting & talking with someone ____Sitting inactive in a public space ____Watching TV

FAMILY HISTORY

How many (living or deceased): Brothers _____ Sisters _____

How many (living or deceased): Sons _____ Daughters _____

Any family members diagnosed with the following? Please indicate all that apply with M- mother, F- father, S- siblings, C-children, GP-grandparent

Asthma _____	**High cholesterol _____**	**Diabetes _____**
High BP _____	**Mental Illness _____**	**Bleeding disorder ____**
Allergies _____	**Thyroid disorder_____**	**Hearing loss _____**
Headaches _____	**Heart disease _____**	**Cancer, type: _____**

Social History

Relationship status:

Single ____ Married _____ Widow / Widower_____ Divorced _____

Occupation: Employed ____ What field? _____

Retired _____ Homemaker _____

Disabled _____ Reason for disability: _____

Student_____ Unemployed _____

Do you drink Caffeine? YES / NO

If yes, what kind? Coffee, Tea, Soda, Energy drinks

How many a day _____

Do you currently smoke? YES / NO Use chewing tobacco? YES / NO

What do you smoke? Cigarettes___ E-cigarettes ____ Pipe____ Cigars____ Hookah___

OVER->

Smoking History

How long have you smoked? _____ How many packs a day? _____

Are you interested in quitting? **YES / NO**

If you have quit smoking, how much and for how long did you smoke?

_____packs a day for _____years QUIT date: _____

Are you frequently exposed to second hand smoke? YES / NO

Do you drink Alcohol? YES / NO

If yes, how many drinks a day? _____ or Weekly? _____

Do you engage in recreational drug use? YES / NO

If yes, what kind? _____For how long? _____

History complete, thank you!

For staff use: Pharmacy?

Height:

Weight:

Blood Pressure:

Pulse:

Resp:

O2 Sat:

(Snoring and apnea pts require a neck circumference)