

# HEALTH HISTORY FORM

Welcome to Valley ENT! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Last Name:	First:	Age:	Date:
<b>What problem are you here for today?</b>			
<b>Current Medications: List all current medications, dose &amp; frequency (include over-the-counter and herbals):</b>			
<b>List any known allergies/the reaction:</b>			
<b>List all current medical problems:</b>			
<b>List any other medical problems not stated above:</b>			
<b>List your surgeries and their dates (include tonsillectomy and adenoidectomy):</b>			

Date: \_\_\_\_\_



<b>Family History:</b>			
<b>Relation</b>	<b>Alive?</b>	<b>Age:</b>	<b>Medical Problems/Cause of Death</b>
Father	Y N		
Mother	Y N		
Brother/Sister	Y N		
Other			
<b>Please circle "Yes" or "No" to indicate whether any member of your family has any of the following illnesses: If yes, please indicate which relative(s) have the problem:</b>			
Hearing problems	Yes No	Relative:	
Heart Problems	Yes No	Relative:	
Allergy	Yes No	Relative:	
Diabetes	Yes No	Relative:	
Cancer	Yes No	Relative:	
Bleeding disorders	Yes No	Relative:	
Anesthesia problems	Yes No	Relative:	
Thyroid Disease	Yes No	Relative:	

<b>Social History:</b>			
Do you currently smoke or use chewing tobacco?	Yes	No	
How much?			
If no, did you ever smoke?	Yes	No	If yes, number of years:
Do you drink alcohol?	Yes	No	
How much per day/week?			
Marital Status:	Married	Single	Divorced Widowed
Whom do you live with?			
Are you employed?	Yes	No	Briefly explain your work environment.
Environmental risks?	Any chemicals, hazards or noise exposure?		

<b>If you snore, please complete this section:</b>	
Choose the number that best fits your response and place under "Your Score": 0=Never    1=Infrequently (1 night per wk)    2=Frequently (2-3 nights per wk)    3=Most of the time	
<b>Situation</b>	<b>Your Score</b>
My snoring affects my relationship with my partner	_____
My snoring causes my partner to be irritable or tired	_____
My snoring requires us to sleep in separate rooms	_____
My snoring is loud	_____
My snoring affects other people when I am sleeping away from home (hotel, camping, etc)	_____
<b>TOTAL SCORE</b>	_____

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_