

Associates in Otolaryngology Health History

Date: _____

Joseph Oyer, MD

Jonathon Sillman, MD

Andrea Chiaramonte, MD

James Hughes, MD

Patient Name: _____

DOB: _____

Social History

Alcohol: Yes No
 Smoking: Yes No
 Recreational drug use: Yes No
 Exercise: Yes No
 Passive smoke exp: Yes No
 Caffeine: Yes No
 Pets: Yes No
 Day Care Yes No
 Marital status Yes No
 Chewing tobacco Yes No

Family History

Mother alive deceased unknown
 Father alive deceased unknown
 Siblings alive deceased unknown
 Children 0 1 2 3 4 >4
 Grandmother alive deceased unknown
 Grandfather alive deceased unknown

Occupation: attorney physician engineer teacher computer/IT
 finance construction/factory retail student retired other

PSYCHOLOGY

suicidal ideation Yes No
 eating disorder Yes No
 mental or physical abuse Yes No
 anxiety Yes No
 hallucinations Yes No
 impulsive behavior Yes No
 depression Yes No

MUSCULOSKELETAL

joint stiffness Yes No
 leg cramps Yes No
 joint pain Yes No
 joint swelling Yes No
 sciatica Yes No
 osteoporosis treatment Yes No
 fracture Yes No
 back pain Yes No

CONSTITUTIONAL

weight gain Yes No
 loss of appetite Yes No
 fever Yes No
 weakness Yes No

CONSTITUTIONAL

weight loss Yes No
 fatigue Yes No
 ambulation (able to walk) Yes No
 breast feeding Yes No
 crankiness Yes No

CARDIOLOGY

palpitations Yes No
 leg edema Yes No
 shortness of breath Yes No
 high Blood Pressure Yes No
 murmur Yes No
 cyanosis (blue skin) Yes No

GASTROENTEROLOGY

blood in stool Yes No
 diarrhea Yes No
 vomiting Yes No
 constipation Yes No
 nausea Yes No
 difficulty swallowing Yes No
 heartburn Yes No
 hoarseness Yes No
 jaundice (yellow skin) Yes No

**Associates in Otolaryngology
Health History**

Patient Name: _____

Date of Birth: _____

DERMATOLOGY

rash Yes No
mole Yes No
lumps Yes No
dry or sensitive skin Yes No
hives Yes No
acne Yes No
skin cancer Yes No

RESPIRATORY

shortness of breath Yes No
chest congestion Yes No
cough Yes No
recent bronchitis Yes No
wheezing Yes No
coughing up blood Yes No

ENDOCRINOLOGY

fatigue Yes No
excessive thirst Yes No
frequent urination Yes No
weight loss Yes No
sleep disturbance Yes No
cold intolerance Yes No
heat intolerance Yes No
diabetes Yes No
thyroid disease Yes No

ALLERGY

sneezing Yes No
itchy eyes Yes No
eczema Yes No

HEMATOLOGY/LYMPH

varicose veins Yes No
easy bruising Yes No
easy bleeding Yes No

NEUROLOGY

headache Yes No
tingling numbness Yes No
seizures Yes No
insomnia (difficulty sleeping) Yes No
memory loss Yes No
walking abnormality Yes No
extremity weakness Yes No
slurring of speech Yes No

OPHTHALMOLOGY

diminished vision Yes No
eye irritation Yes No
drainage from eyes Yes No
blurring of vision Yes No
seasonal eye symptoms Yes No
dander related eye symptoms Yes No
loss of vision Yes No
swelling/pain around eye Yes No