Associates in Otolaryngology
Health History

Date:_________________

Joseph H. Oyer, M.D. **Jonathon Sillman, M.D.** **Andrea C. Chiaramonte, M.D.**

Patient Name: DOB:

Social History

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

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

Family History

Mother	O alive	O deceased	O unknown
Father	O alive	O deceased	O unknown
Siblings	O alive	O deceased	O unknown
Grandmother	O alive	O deceased	O unknown
Grandfather	O alive	O deceased	O unknown

Children O 0 O 1 O 2 O 3 O 4 O >4

PSYCHOLOGY

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

MUSCULOSKELETAL

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

CONSTITUTIONAL

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

CONSTITUTIONAL

weight loss	O Yes	O No
fatigue	O Yes	O No
ambulation:	O Yes	O No
breast feeding	O Yes	O No
crankiness	O Yes	O No

CARDIOLOGY

palpitations	O Yes	O No
leg edema	O Yes	O No
shortness of breath	O Yes	O No
high Blood Pressure	O Yes	O No
murmur	O Yes	O No
cyanosis	O Yes	O No

GASTROENTEROLOGY

blood in stool	O Yes	O No
diarrhea	O Yes	O No
vomiting	O Yes	O No
constipation	O Yes	O No
nausea	O Yes	O No
dysphagia	O Yes	O No
heartburn	O Yes	O No
hoarseness	O Yes	O No
jaundice	O Yes	O No

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Patient Name:___________________________ **Date of Birth**:_____________________

DERMATOLOGY

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

ENDOCRINOLOGY

fatigue	O Yes O No
excessive thirst	O Yes O No
polyuria	O Yes O No
weight loss	O Yes O No
sleep disturbance	O Yes O No
cold intolerance	O Yes O No
heat intolerance	O Yes O No
diabetes	O Yes O No
thyroid disease	O Yes O No

NEUROLOGY

headache	O Yes O No
tingling numbness	O Yes O No
seizures	O Yes O No
insomnia	O Yes O No
memory loss	O Yes O No
gait abnormality	O Yes O No
extremity weakness	O Yes O No
slurring of speech	O Yes O No

OPTHALMOLOGY

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

RESPIRATORY

shortness of breath	O Yes O No
chest congestion	O Yes O No
cough	O Yes O No
recent bronchitis	O Yes O No
wheezing	O Yes O No
hemoptysis	O Yes O No

ALLERGY

sneezing	O Yes O No
itchy eyes	O Yes O No
eczema	O Yes O No

HEMATOLOGY/LYMPH

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