EASTERN CONNECTICUT EAR, NOSE & THROAT, P.C.

MEDICAL HISTORY

PATIENT:____ DATE OF BIRTH:_________________________

PHARMACY: ____ LOCATION: _____________________________

WHAT BRINGS YOU IN TODAY: ___________________________________ HEIGHT: __________ WEIGHT: ________

PAST MEDICAL HISTORY – PLEASE CIRCLE ALL THAT APPLY TO YOU

AIDS/HIV	**ADD**	**COLITIS, UNCERATIVE**	**HEPATITIS A B C**	**HEART ATTACK**	**SJOGREN'S SYNDROME**
ANEMIA	**HIGH BLOOD PRESSURE**	**CONGESTIVE HEART FAILURE**	**HIGH CHOLESTEROL**	**PERIPHERAL VASCULAR DISEASE**	**SLEEP APNEA**
ANEURYSM	**BIPOLAR DISORDER**	**CROHN'S DISEASE**	**OVERACTIVE THYROID**	**SKIN CANCER SITE:**	**STROKE/TIA**
ANGINA	**BLINDNESS**	**DEMENTIA**	**UNDERACTIVE THYROID**	**BLOOD CLOTS**	**OTHER;**
ANXIETY	**BRAIN TUMOR**	**DEPRESSION**	**IRRITABLE BOWEL**	**CURRENT PREGNANCY**	
ARTHRITIS	**CANCER SITE:**	**DIABETES**	**LUPUS**	**PROSTATE CONDITION**	
ASTHMA	**COPD**	**ESOPHAGEAL STRICTURE**	**LYME DISEASE**	**PULMONARY EMBOLISM**	
ATRIAL FIBRILLATION	**CIRRHOSIS**	**REFLUX/ HEARTBURN**	**MRSA SITE:**	**RENAL FAILURE**	
ADHD	**BLEEDING DISORDER**	**GLAUCOMA**	**FIBROMYALGIA**	**SEIZURE DISORDER**	

PAST SURGERIES:

__ Ear Tubes **__ Sinus Surgery** **__ Angioplasty/Stents** **__ Hysterectomy**
__ Tonsillectomy **__ Nasal Fracture** **__ Appendix** **__ Cataracts**
__ Adenoidectomy **__ Ear Surgery** **__ Gallbladder**

OTHER:____

MEDICATIONS: List all medications and dosages (Include over the counter medications)

____

____

ALLERGIES: List all medication allergies and reactions

____

____

Latex Allergy: ____ Yes ____ No Reaction: ______________________________
Shellfish Allergy: ____Yes _____No Reaction: ______________________________
Iodine Allergy: ____Yes _____No Reaction: ______________________________

FAMILY HISTORY:

Bleeding disorders that run in family? Yes No Who? ______________________________
Head and Neck cancer? (Please circle which) Yes No Who? ______________SITE:___________
Thyroid cancer? Yes No Who? ______________________________
Diabetes? Yes No Who? ______________________________

36 Watson Street, Willimantic, CT 06226 – 79 Wawecus Street, Norwich, CT 06260 – 121 Broadway, Colchester, CT 06415
860-456-0287 – 860-886-6610 – 860-537-1903
Fax: 860-456-3532
www.EasternCTENT.com

MEDICAL HISTORY

SOCIAL HISTORY: Please circle

Alcohol: Never / Current / Former Amount per day: _______

Recreational drugs: Never / Current / Former Type: Marijuana / Cocaine / Heroin /other How often:________

Tobacco: Never / Current / Former Type: Cigarettes / Cigars / Pipe / E-Cigarettes / Chew

Amount per day: _______ How many years:_______ Year quit:_______

Current Second hand smoke exposure: _____No _____ Yes Location: _____ Home _____ Work

REVIEW OF SYSTEMS

PLEASE CIRCLE ALL THAT APPY:

General	Weight loss	Weight gain	Generalized weakness	
Cardiovascular	Chest pain	Rapid heart rate	Passing out	
Respiratory	Shortness of breath	Wheezing	Cough	
Gastrointestinal	Nausea	Vomiting	Diarrhea	
Skin	Rash	Itching	Color changes	
Eyes	Double vision	Change in vision	Excessive tearing	Dry eye
Neurologic	Hearing loss	Speech difficulties	Seizures	Incoordination
Musculoskeletal	Joint pain	Joint swelling	Muscle pain	
Endocrine	Cold intolerance	Heat intolerance		
Heme-Lymph	Easy bleeding	Easy bruising	Lymph node enlargement	
Allergic/Immunologic	Hives	Frequent infections	Eczema	

PATIENT'S SIGNATURE: ___________________________________ **DATE**: __________ **Reconciled: __________**

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