

**ORLANDO EARS, NOSE AND THROAT  
HEALTH HISTORY  
(CONFIDENTIAL)**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS.

**SYMPTOMS:**

**MUSCLE/JOINT/BONE**

Neck

**GASTROINTESTINAL**

Indigestion

Peptic Ulcers

**CARDIOVASCULAR**

Chest pain

High blood pressure

Irregular heart beat

Low blood pressure

**EARS/NOSE/THROAT**

Difficulty swallowing

Ear discharge

Hay fever

Hoarseness

Loss of hearing

Nose bleeds

Persistent cough

Ringing in ears

Sinus problems

**SKIN**

Change in moles

**CONDITIONS:**

Anemia

Arthritis

Asthma

Bleeding Disorders

Bronchitis

Cancer

Colitis

Crohn's Disease

Diabetes

Emphysema

Heart Disease

Liver Disease

Lupus

Migraine Headaches

Mononucleosis

Pace Maker

Pneumonia

Prostate Problems

Stroke

Thyroid Problems

Tonsillitis

Tuberculosis

Other \_\_\_\_\_

**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:**

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:**

\_\_\_\_\_  
\_\_\_\_\_

I drink alcohol \_\_\_ times a day \_\_\_ times a week.

I smoke \_\_\_ cigarretes(pipes or cigars) a day.

I drink \_\_\_ cups of coffee, coke, tea a day.