THE CENTERS FOR ADVANCED ENT CARE

Form updated 12/11/20

Central ENT Consultants, PC

PATIENT HEALTH HISTORY / BUBBLE SHEET

PATIENT NAME:___________________________DOB:____ /____ /____

Please circle **YES** if it applies to you **currently, or has applied to you in the past**. Please circle **NO** if the following **does not or has not ever** applied to you.

Past Medical History

Acid reflux/Heartburn:	YES	NO	AIDS/HIV:	YES	NO
Hypertension/Heart disease:	YES	NO	Diabetes	YES	NO
Asthma:	YES	NO	Barretts Esophagus:	YES	NO
Cancer, basal cell:	YES	NO	Cancer, esophageal:	YES	NO
Cancer, larynx:	YES	NO	Cancer, mouth:	YES	NO
Sleep Apnea:	YES	NO	Other:_____________	YES	NO

Social History

Drink alcohol:	YES	NO	Smoke Marijuana:	YES	NO
Tobacco use:	YES	NO			

Have you used drugs other than for medical reasons in the past 12 months? YES NO

General

Fatigue:	YES	NO	Headaches:	YES	NO
Lightheadedness:	YES	NO	Sleep disturbance:	YES	NO

Allergy/Immunology

Nasal congestion:	YES	NO	Cough:	YES	NO
Recurrent sinus infections:	YES	NO	Seasonal Allergies:	YES	NO
Sneezing:	YES	NO	Watery Eyes:	YES	NO

Unusual reaction to medication(s), food, animals, or insects? YES NO

Have you or a family member has had a problem with anesthesia? YES NO

ENT

Blocked ear:	YES	NO	Broken nose:	YES	NO
Decreased hearing:	YES	NO	Decreased smell:	YES	NO
Difficulty swallowing:	YES	NO	Deviated septum:	YES	NO
Dry mouth:	YES	NO	Ear pain:	YES	NO
Ear problems:	YES	NO	Nosebleed:	YES	NO
History of broken nose:	YES	NO	Ringing in the ears:	YES	NO
Mouth breathing at night:	YES	NO	Sinus/Facial pain:	YES	NO
Snoring:	YES	NO	Sore throat:	YES	NO
Swollen glands:	YES	NO	Nasal polyps:	YES	NO
Von Willebrand's Disease:	YES	NO	Chronic sinusitis:	YES	NO

Endocrine

Diabetes:	YES	NO	Difficulty sleeping:	YES	NO
Dizziness:	YES	NO	Thyroid problems:	YES	NO
Goiter:	YES	NO	Grave’s Disease:	YES	NO