AIRWAY ALLIANCE ENT
CHRISTOPHER TRAN, MD

MEDICAL HISTORY FORM

Patient name:_____Date of Birth:_____Date of Appointment:_____

Have you had any of the following withing the last two weeks?

You may circle if YES ONLY!

CONSTITUTIONAL

Fever	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Loss of Appetite	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No

Have you ever had or do you have any of these problems?

ENT

Hearing loss	☐Yes	☐No
Dizziness	☐Yes	☐No
Infections	☐Yes	☐No
Ear discharge	☐Yes	☐No
Nose Trauma	☐Yes	☐No
Nose Obstruction	☐Yes	☐No
Snoring	☐Yes	☐No
Nasal discharge	☐Yes	☐No
Bleeding	☐Yes	☐No
Postnasal drip	☐Yes	☐No
Ringing in the ears	☐Yes	☐No

ENT

Soreness	☐Yes	☐No
Difficulty Swallowing	☐Yes	☐No
Tonsillitis	☐Yes	☐No
Voice change	☐Yes	☐No
Hoarseness	☐Yes	☐No
Sinus pain	☐Yes	☐No
Sinus swelling	☐Yes	☐No
Sinus pressure	☐Yes	☐No
Frequent sinus infection	☐Yes	☐No
Crowns	☐Yes	☐No
Root canals	☐Yes	☐No
TMJ	☐Yes	☐No
Dental Trauma	☐Yes	☐No

OPTHALMOLOGY

Blurring of vision	☐Yes	☐No
Double vision	☐Yes	☐No
Decrease visual acuity	☐Yes	☐No

RESPIRATORY

Coughing up blood	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Wheezing	☐Yes	☐No

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You may mark YES ONLY!

CARDIOLOGY

Chest pain	☐Yes	☐No
Rheumatic fever	☐Yes	☐No
Heart Attack	☐Yes	☐No
High Cholesterol	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Leg edema	☐Yes	☐No
Murmur	☐Yes	☐No
Palpitations	☐Yes	☐No

UROLOGY

Kidney stones	☐Yes	☐No
Infections	☐Yes	☐No
Tumor	☐Yes	☐No
Recurrent UTI	☐Yes	☐No
Urinary retention	☐Yes	☐No
Urinary incontinence	☐Yes	☐No

ENDOCRINOLOGY

Thyroid disease	☐Yes	☐ No
Weight gain	☐Yes	☐No
Weight loss	☐Yes	☐No
Diabetes	☐Yes	☐No
Heat/Cold Intolerance	☐ Yes	☐No

NEUROLOGY

Stroke	☐Yes	☐No
Epilepsy	☐Yes	☐No
Seizures	☐Yes	☐No
Migraines	☐Yes	☐No

PSYCHOLOGY

Depression	☐Yes	☐No
Anxiety	☐Yes	☐No
Mental Illness	☐Yes	☐No
Alcoholism	☐Yes	☐No
Drug dependency	☐Yes	☐No
ADHD	☐Yes	☐No

GASTROENTEROLOGY

Jaundice	☐Yes	☐No
Liver disease	☐Yes	☐No
Abdominal pain Yes	☐Yes	☐No
Constipation	☐Yes	☐No
Diarrhea	☐Yes	☐No
Reflux	☐Yes	☐No
Ulcers	☐Yes	☐No

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You may mark YES ONLY!

MUSCULOSKELETAL

Arthritis	☐Yes	☐No
Back pain	☐Yes	☐No
Neck pain	☐Yes	☐No

ALLEGY

Asthma	☐Yes	☐No
Hay fever	☐Yes	☐No
Hives	☐Yes	☐No
Eczema	☐Yes	☐No
Scratchy throat	☐Yes	☐No
AIDS	☐Yes	☐No
HIV positive	☐Yes	☐No
Immune Deficiency	☐Yes	☐No

DERMATOLOGY

Rash	☐Yes	☐No
Dry/Sensitive Skin	☐Yes	☐No
Hives	☐Yes	☐No
Skin cancer	☐Yes	☐No

HEMATOLOGY/LYMPH

Easy bruising	☐Yes	☐No
Hepatitis C	☐Yes	☐No
Swollen glands	☐Yes	☐No

SOCIAL HISTORY

Employed	☐Yes	☐No
Alcohol	☐Yes	☐No
Recreational drug use	☐Yes	☐No
Caffeine	☐Yes	☐No
Passive smoke exp	☐Yes	☐No
Oral Tobacco	☐Yes	☐No

FAMILY HISTORY BLOOD RELATIVE

Hearing loss	☐Yes	☐No
Thyroid disease	☐Yes	☐No
Heart disease	☐Yes	☐No
Diabetes	☐Yes	☐No
Reaction to Anesthesia	☐Yes	☐No
Coronary Artery disease	☐Yes	☐No
Cancer	☐Yes	☐No
Bleeding problems	☐Yes	☐No
Hypertension	☐Yes	☐No
Gout	☐Yes	☐No
Stroke	☐Yes	☐No
Lupus	☐Yes	☐No