Tel 212.233.2266 | Fax 888.368.1539
info@sohoent.com | www.sohoent.com
198 Canal Street, Suite 403, New York, NY 10013

Soho Otolaryngology Adult Medical History Form

Patient Name _____ DOB _____ Wt_____ Ht _____ Today's date _____

Please answer this questionnaire to the best of your knowledge. The information is confidential and will be used by the staff of Soho Otolaryngology for evaluation and treatment.

WHAT IS YOUR COMPLAINT TODAY? _____

1. MEDICATIONS: List all your current over the counter and prescription medications with dosages if known.

_____

_____

2. ALLERGIES: Are you allergic to any medications? foods? What kind of reaction?

_____

3. SOCIAL (Please circle your response)

Do you drink alcoholic beverages? Yes No Occasional Moderate Heavy
Do you use tobacco? Yes No Never smoked Previous smoker Chew
Smoke < 1 pack/day | 1-2 pack/day | 2-3 pack/day | How many years? ___
Do you use any recreational drugs? Yes No | Please list:

4. ILLNESSES OR CONDITION: Are you under the care of a doctor for a specific illness/condition or have you been treated in the past for: (Please check your response) If so, please provide details

_____

_____

	Yes No		Yes No
Allergies	( ) ( )	Kidney/Bladder problems	( ) ( )
Anemia	( ) ( )	Lungs	( ) ( )
Asthma	( ) ( )	Meningitis	( ) ( )
Autoimmune disease	( ) ( )	Migraine Headaches	( ) ( )
Bleeding disorders	( ) ( )	Mitral Valve Prolapse	( ) ( )
Bone or joint	( ) ( )	Nasal Trauma	( ) ( )
Cancer	( ) ( )	Nervous System problems	( ) ( )
Chemical Dependency	( ) ( )	Nosebleeds	( ) ( )
COPD	( ) ( )	Reflux/GERD/heartburn	( ) ( )
Diabetes	( ) ( )	Seizure Disorder	( ) ( )
Hearing Loss	( ) ( )	Sinusitis	( ) ( )
Heart	( ) ( )	Sleep Apnea	( ) ( )
Hepatitis	( ) ( )	Stomach or Bowel problems	( ) ( )
HIV	( ) ( )	Thyroid	( ) ( )
High Cholesterol	( ) ( )	Tinnitus/Ringing in the ears	( ) ( )
Hypertension	( ) ( )	Tuberculosis	( ) ( )

5. SURGERIES: Please list any ear, nose and throat surgeries and any other major surgeries/hospitalizations in your lifetime.

_____

_____

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6. Does anyone in your family have the following medical problems?: If so, please provide details

_____

_____

	YES NO		YES NO
Allergies	( ) ( )	Premature Hearing Loss	( ) ( )
Asthma	( ) ( )	Sinusitis	( ) ( )
Autoimmune Disease	( ) ( )	Sleep Apnea	( ) ( )
ENT related cancers	( ) ( )	Thyroid Disorders	( ) ( )
Migraine Headaches	( ) ( )	Cancers, other	( ) ( )

7. REVIEW OF SYSTEMS:

Have you experienced any of these symptoms in the past month?

	YES NO		YES NO
Nasal Allergy	( ) ( )	Chest Pain	( ) ( )
Post-nasal Discharge	( ) ( )	High Blood Pressure	( ) ( )
Sinus Infection(s)	( ) ( )	Stroke	( ) ( )
Nose Bleeds	( ) ( )	Diabetes	( ) ( )
Headaches	( ) ( )	Ulcers	( ) ( )
Dizziness	( ) ( )	Other Stomach Disease	( ) ( )
Tinnitus (ringing in ear)	( ) ( )	Anemia	( ) ( )
Hearing Loss	( ) ( )	Visual Problems	( ) ( )
Difficulty Breathing	( ) ( )	Glaucoma	( ) ( )
Difficulty Swallowing	( ) ( )	Thyroid Disease	( ) ( )
Asthma	( ) ( )	Hepatitis (Liver)	( ) ( )
Hay fever	( ) ( )	kidney Disease	( ) ( )
Tuberculosis	( ) ( )	Convulsive Disorder	( ) ( )
Lung Disease	( ) ( )	Positive HIV Testing	( ) ( )
Heart Trouble	( ) ( )	Exposure to HIV	( ) ( )

Primary Physician _____ Fax: _____ Tel: _____

Address: _____

FOR INTERNAL USE ONLY: 31231 31575 31579 69200 69210 Other: _____

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