HELENA EAR, NOSE & THROAT CLINIC

**Dr. Scott Pargot, DO**
**Dr. Nathan Sanders, DO**

**Patient Name**_____

Age_____Date of Birth_____

Preferred Pharmacy_____

Referring Physician_____Primary Care Provider_____

## CURRENT MEDICAL CONDITION

What current problems are you experiencing? Describe your symptoms_____

_____

_____Date of Onset of Condition_____

## LIST ALL PREVIOUS SURGERIES

_____

_____

## PERSONAL MEDICAL HISTORY

| | | | |
|---|---|---|---|
| ☐High Blood Pressure | ☐Tonsillectomy | ☐ Anemia | ☐Cancer,specify( ) |
| ☐Stroke | ☐History of Ear Tubes | ☐HIV or AIDS | ☐Migraines/Headaches |
| ☐Heart Problems/CHF | ☐Asthma | ☐Bleeding disorders | ☐Vertigo/Dizziness |
| ☐Cardiac Pacemaker | ☐Allergies/Hay Fever | ☐Blood Transfusion | ☐Diabetes |
| ☐Heart Attack/Heart Murmur | ☐Difficulty breathing/wheezing | ☐Chronic Cough | ☐Snoring/Sleep Apnea/CPAP |
| ☐Chronic Ear Infection | ☐Emphysema/COPD | ☐Difficulty Swallowing | ☐Hearing Loss/Hearing Aides |
| ☐Sinus Surgery | ☐Arthritis | ☐Acid Reflux/GERD | ☐Liver or Kidney Disease |
| ☐Septoplasty | ☐Autoimmune Disorder | ☐Thyroid Problems | ☐Epilepsy |
| ☐Chronic Sinusitis | ☐Hepatitis | ☐Psychiatric Disorders (Depression, Schizophrenia, etc) | |

☐Other_____

## ALLERGIES TO MEDICATIONS

Please list any medication allergies including the type of reaction:_____

_____

## MEDICATIONS

**Please list all of the medications** that you are currently taking (**include over the counter and herbal medications)**

| **Medication** | **Dose** | **Medication** | **Dose** |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |
| | | | |

## FAMILY MEDICAL HISTORY

**Please check all the diseases that run in your family**

| Disease | Mother | Father | Grandparent | Sibling | Children |
|---|---|---|---|---|---|
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Respiratory or Lung Problems | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding Disorder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anesthesia Reaction | ☐ | ☐ | ☐ | ☐ | ☐ |
| Neuromuscular Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Significant Disease | | | | | |

## SOCIAL HISTORY

Weight_____ Height_____

Do you currently smoke or did you ever smoke? ☐**Yes** ☐**No** If yes, Packs/Day_____ Years_____

Do you chew tobacco or smoke a pipe or cigar? ☐**Yes** ☐**No** If yes, how much per day? Years_____

If you no longer smoke or chew, when did you quit?_____

How many drinks of alcohol do you have in a typical week?_____