Alyeska ENT
Patient Health History

ENT Specialists OF ALASKA

Last Name _____ First Name _____ Date of Visit _____

How did you hear about us? _____ Weight _____

Reason for Visit _____

Medical History
Do you now or have you ever had a history of:

Abnormal bleeding or a bleeding disorder	❍ Yes	❍ No
Anesthetic complications	❍ Yes	❍ No
Diabetes	❍ Yes	❍ No
Heart disease (heart attack, chest pains, irregular heartbeat, congestive failure)	❍ Yes	❍ No
Lung disease	❍ Yes	❍ No
Wound healing complications	❍ Yes	❍ No
Keloids or poor scarring	❍ Yes	❍ No
Heart murmur requiring preventative antibiotics	❍ Yes	❍ No
Radiation treatments	❍ Yes	❍ No
Tuberculosis	❍ Yes	❍ No
Hepatitis or liver disease	❍ Yes	❍ No
Gastric or peptic ulcers	❍ Yes	❍ No
Stroke	❍ Yes	❍ No
Cancer	❍ Yes	❍ No
Kidney disease	❍ Yes	❍ No
Psychiatric illness	❍ Yes	❍ No
Implants or artificial devices (heart valve, joints, lens, pacemaker)	❍ Yes	❍ No
Eye disease (glaucoma, retinal detachment, cataracts)	❍ Yes	❍ No
High blood pressure	❍ Yes	❍ No
Inflammatory or autoimmune disease (lupus, wegener's, sarcoid, MS)	❍ Yes	❍ No
HIV or AIDS	❍ Yes	❍ No
Family history of abnormal bleeding or anesthetic complications	❍ Yes	❍ No
Other medical problems	❍ Yes	❍ No
Do you have any religious reason why you would not accept blood products?	❍ Yes	❍ No
Have you or anyone in your family been treated for a MRSA skin infection?	❍ Yes	❍ No
Do you have history of contracting COVID-19?	❍ Yes	❍ No
Are you vaccinated for COVID-19?	❍ Yes	❍ No

If you answered yes to any of the above, please provide details below: _____

_____

List all prescriptive and over-the-counter medications: _____

_____

List all allergies to medications: _____

_____

List all prior surgeries and hospitalizations: _____

_____

_____

Please complete other side

Name _____ Date of Birth _____

Family and Social History

Occupation _____

Tobacco use (cigarettes, cigars, pipes, chew, snuff) _____ Years of use _____ Packs per day _____ Year quit _____

Do you consume alcoholic beverages regularly? ❍ Yes ❍ No

Do you use illicit or addictive drugs (cocaine, marijuana, etc.) ❍ Yes ❍ No

If female, is there a chance you might be pregnant? ❍ Yes ❍ No

Please list any illnesses that run in your family: _____

_____

_____

Check any of the following that you are currently or have previously experienced:

General

Rashes/bruising/skin problems	❍ Now	❍ Past
Recent weight loss or gain	❍ Now	❍ Past
Fatigue	❍ Now	❍ Past
Fever/chills/night sweats	❍ Now	❍ Past

Sleep Disturbance

Loud snoring	❍ Now	❍ Past
Excessive sleepiness	❍ Now	❍ Past
Breathing stops during sleep	❍ Now	❍ Past
Wake up feeling unrested	❍ Now	❍ Past

Cardiopulmonary

Heart murmur	❍ Now	❍ Past
Palpitations	❍ Now	❍ Past
Chest pain	❍ Now	❍ Past
Shortness of breath	❍ Now	❍ Past
Wheezing	❍ Now	❍ Past
Chest tightness	❍ Now	❍ Past

Nervous System

Numbness	❍ Now	❍ Past
Tingling	❍ Now	❍ Past
Fainting	❍ Now	❍ Past
Weakness	❍ Now	❍ Past

Endocrine

Heat/cold intolerance	❍ Now	❍ Past
Excessive thirst	❍ Now	❍ Past
Change in shoe/hand size	❍ Now	❍ Past

Eyes

Clouded vision	❍ Now	❍ Past
Dry eyes	❍ Now	❍ Past
Double vision	❍ Now	❍ Past

Ears

Ringing	❍ Now	❍ Past
Hearing loss	❍ Now	❍ Past
Dizziness/vertigo	❍ Now	❍ Past
Pain	❍ Now	❍ Past
Drainage	❍ Now	❍ Past

Mouth/Throat

Dryness	❍ Now	❍ Past
Hoarseness	❍ Now	❍ Past
Choking	❍ Now	❍ Past
Difficulty swallowing	❍ Now	❍ Past
Lumps in neck	❍ Now	❍ Past
Painful swallowing	❍ Now	❍ Past

Nose

Nasal congestion	❍ Now	❍ Past
Nasal drainage	❍ Now	❍ Past
Facial pressure/pain	❍ Now	❍ Past
Nasal bleeding	❍ Now	❍ Past

Gastrointestinal

Indigestion/heartburn	❍ Now	❍ Past
Nausea/vomiting	❍ Now	❍ Past
Change in stool color	❍ Now	❍ Past
Diarrhea/constipation	❍ Now	❍ Past
Abdominal pain	❍ Now	❍ Past