DEMERA

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Ear, Nose and Throat Medical History

Patient Name: _____ DOB: _____ Date: _____

Age: _____ Sex: _____ Ht: _____ Wt: _____ BMI: _____

Primary Physician: _____ Referring Physician: _____

Reason for Visit: _____

GENERAL EAR, NOSE AND THROAT QUESTIONS:

Do you have a history of surgery to the ear(s), nose, mouth, throat, or neck? ..... YES / NO
If so, what type and when? _____

Do you have hearing loss? ..... YES / NO
If so, how long? When was your last hearing test? _____

Do you wear hearing aids? ..... YES / NO
If so, how long? When were they purchased? _____

Do you experience ringing of the ears? ..... YES / NO
If so, how long? Describe the sound: _____

Do you have problems with vertigo? ..... YES / NO
If so, how long? Studies? _____

Do you have a history of GERD? ..... YES / NO
If so, diagnosis made when? Tests performed? _____

Do you have a change in voice? ..... YES / NO

Do you have trouble or pain with your voice or with swallowing? ..... YES / NO

Do you drink alcoholic beverages? ..... YES / NO
If so, how frequently? How much? _____

Do you smoke? ..... YES / NO
If so, what do you smoke? How often? _____

Do you snore or have sleep apnea? ..... YES / NO
If so, are you on CPAP? ..... YES / NO

Do you fall asleep easily (or too easily)? ..... YES / NO

Do you breathe normally through your nose? ..... YES / NO

Medical History (check box if applicable and explain):

☐ Allergies ☐ Sinus Problems ☐ Recurrent Facial Pain ☐ Thyroid Disease, Nodules, or Masses

☐ Masses/Cancers of the ear, nose, oral cavity, throat, head or neck ☐ Recurrent wax impaction/Mastoid bowl hygiene

Other/Explain: _____

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