

MEDICAL HISTORY

Name: _____ Date of Birth: _____ Date: _____

Have you had the following problems (include both past and present):

General:

- Weight loss Yes No
- Fatigue Yes No
- Frequent fever or chills Yes No

Eyes:

- Pain Yes No
- Visual loss Yes No
- Double vision Yes No
- Blindness Yes No
- Glasses/contacts Yes No

Respiratory:

- Coughing Yes No
- Bronchitis Yes No
- Asthma Yes No
- Emphysema Yes No

Gastrointestinal:

- Heartburn Yes No
- Frequent nausea/vomiting Yes No
- Cancer Yes No

Cardiac:

- Chest pain Yes No
- Rapid/irregular heart beat Yes No
- High blood pressure Yes No
- Heart attack Yes No
- Pacemaker Yes No

Genitourinary:

- Kidney/bladder infections Yes No
- Kidney stones Yes No

Female:

- Pregnant Yes No

Extremities:

- Joint pain Yes No
- Muscle pain Yes No
- Back pain Yes No
- Arthritis Yes No

Psych:

- Depression Yes No
- Other Yes No

TYPE	TREATMENT	STATUS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature _____

If you have questions, please contact ENT Nebraska at 402.484.5500.