HUNTERDON OTOLARYNGOLOGY & Allergy Associates

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Christine Cairns, M.D. • Melinda Wentz, APN • Casey Otto, Au.D. • Diana Anderson, Au.D.

HEALTH HISTORY

Patient's Name: _____ Date of Birth: _____

Preferred Pharmacy: _____ Mail-Away Pharmacy: _____

Pharmacy Location: _____

DRUG ALLERGIES

Are you allergic to any medications? ☐ No ☐ Yes (Please list the medication and your reaction below)

MEDICATION	What Was Your Reaction?

FAMILY HISTORY (Not your personal history)		
Check Please	Condition	Please enter any details that may be pertinent. If a family member died because of the condition, please enter the family member's relationship to you and their age at the time of death.
	Allergies	
	Asthma	
	Autoimmune Disease	
	Coronary Artery Disease (CAD)	
	Cancer	
	Chronic Otitis Media	
	Cleft Lip/Palate	
	Complications Related to Anesthesia	
	CVA (Stroke)	
	Depression	
	Developmental Delay	
	Diabetes	
	GERD	
	Hearing Disorder	
	Hematological Disorder	
	Hyperlipidemia	
	Hypertension (High Blood Pressure)	
	Migraines	
	Obesity	
	Otosclerosis	
	Renal Disease	
	Seizure Disorder	
	Sickle Cell Disease	
	Sleep Apnea	
	Thyroid Disorder	

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SOCIAL HISTORY (Adult patients only)

Occupation: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Disabled

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Current ☐ Former ☐ Never

If you marked "current" or "former," please fill out below:

Type: _____

Units Per Day: _____

Years Used: _____

Alcohol Use: ☐ No ☐ Yes ☐ Former

If you marked "yes" or "former," please fill out below:

Type: _____

Units Per Day: _____

Years Used: _____

SOCIAL HISTORY (Pediatric patients only)

The pediatric patient resides with: _____

Who has legal custody of the pediatric patient? _____

Does anyone in the home smoke? ☐ No ☐ Yes

Does the pediatric patient attend daycare? ☐ No ☐ Yes If so, for how many days per week? _____

PATIENT'S PAST MEDICAL HISTORY

Please mark if you have or have had any of the following. If you have a condition not listed, please enter it in the blank spaces provided.

☐ Anemia	☐ COPD	☐ Headaches	☐ Migraines
☐ Anxiety	☐ Coronary Artery Disease	☐ Heart Disease	☐ Multinodular Goiter
☐ Arthritis	☐ CVA	☐ High Cholesterol	☐ Otosclerosis
☐ Asthma	☐ Depression	☐ Hypertension	☐ Seasonal Allergies
☐ Birth Disorder	☐ Diabetes	☐ Hyperthyroidism	☐ Seizure Disorder
☐ Bleeding Disorder	☐ Emphysema	☐ Hypothyroidism	☐ Sleep Disorder
☐ Cancer	☐ GERD	☐ Intestinal Disorder	☐ Stomach Ulcer
☐ Chronic Infection	☐ ENT Syndromes	☐ Irregular Heart Rate	☐ Tinnitus
☐ Congestive Heart Failure	☐ Graves' Disease	☐ Kidney Disorder	☐ Vertigo
☐ Complications Related to Anesthesia			

PATIENT'S PAST SURGICAL HISTORY

Please list any surgeries you have had and the approximate date of each procedure.

SURGERY	APPROXIMATE DATE