JEFFREY ADELGLASS, M.D., F.A.C.S.
EAR, NOSE & THROAT • ALLERGY • FACIAL PLASTIC SURGERY

HEALTH HISTORY

NAME: _____ AGE: _____ DATE: _____

WHO REFERRED YOU TO OUR PRACTICE? _____

REASON FOR VISIT? _____

WHAT DATE DID SYMPTOMS BEGIN? _____

PROBLEMS (Please Check Appropriate Boxes)

☐ Hearing Loss ☐ Vision Problems ☐ Sore Throat
☐ Vertigo ☐ Nose Congestion ☐ Snoring
☐ Ear Ringing ☐ Nose Discharge ☐ Heartburn
☐ Ear Pain ☐ Post Nasal Drip ☐ Hoarseness
☐ Ear Fullness ☐ Nose Bleeds ☐ Allergies
☐ Dizziness ☐ Headaches ☐ Swallowing Problems
☐ Neck Pain ☐ Neck Mass
☐ Other _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

_____

LIST ANY DRUG ALLERGIES: _____

PAST MEDICAL HISTORY (Please Check Appropriate Boxes)

☐ Heart Attack ☐ Thyroid Disorder ☐ Glaucoma
☐ Asthma ☐ Coronary Disorder ☐ Hypertension
☐ Diabetes ☐ Bleeding Disorder ☐ Heart Failure
☐ Emphysema ☐ Kidney Disorder ☐ Arthritis
☐ Hepatitis ☐ Stroke ☐ Cancer
☐ Other _____

PAST SURGICAL HISTORY (Please Check Appropriate Boxes)

☐ Ear Tubes ☐ Hernia ☐ Back/Neck
☐ Septoplasty ☐ Heart Bypass ☐ Appendix
☐ Sinus Surgery ☐ Cataracts ☐ Gall Bladder
☐ Tonsillectomy ☐ Other _____

FAMILY HISTORY (Please Check Appropriate Boxes)

☐ Strokes ☐ Thyroid Disorders ☐ Hypertension
☐ Diabetes ☐ Allergies ☐ Hearing Loss
☐ Heart Disease ☐ Asthma ☐ Lung Cancer
☐ Breast Cancer ☐ Other _____