Patient History

Rocky Mountain
Ear, Nose & Throat Center, P.C.

Patient Name: _____ Date: _____

Birth Date: _____ Primary Care Physician: _____

Medications & Dosages
(Include **over-the-counter** medications & herbs)

Medical Allergies (list reactions):

Environmental Allergies (plants, animals, food, hayfever, etc):

Allergy Testing:

Review of Systems (circle or write applicable to you)

Constitutional: fever, weight loss, night sweats

Eyes: double vision, blurred vision
glaucoma, cataract,

ENT: hearing loss, sinus problems, swallowing problems

CV: chest pain, irregular heart beat, palpations
heart problems, high blood pressure,

Resp: shortness of breath, wheezing, cough
asthma, emphysema

GI: heartburn, reflux, abdominal pain, diarrhea, vomiting
liver disorders, hepatitis

GU: urinary problems, blood in urine, difficulty urinating

MSK: muscle aches, joint pain, swollen joints

Skin: skin rashes, eczema, itching

Neuro: numbness, weakness, headaches, paralysis,
seizures, stroke

Psychiatric: depression, anxiety,
manic depressive, schizophrenia

Endocrine: hot and cold intolerance
diabetes, thyroid problems

Hematologic/Lymphatic: anemic, easy bleeding
lymphoma, leukemia, bleeding disorders

Allergic/Immunologic: hay fever, allergies,
HIV

Reviewed Patient History/Permanent Sheet *(clinic only)*

Date Reviewed	Asst	MD

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