SOUTHWEST IDAHO
ENT
Ear Nose and Throat, P.A.

Welcome to Southwest Idaho Ear Nose and Throat!

Our physicians strive to provide the best possible care for all patients, and part of this process is obtaining accurate demographic and health history information. To expedite the check-in process for your appointment, we have included in this packet the necessary forms for you to complete in advance.

To ensure a timely check-in process:

- ✓ Please fill out the paperwork completely, bring it with you to your appointment and arrive 15 minutes early.
- ✓ If desired, you may fax your paperwork to our office at (208) 813-1929 prior to your appointment.
- ✓ Your insurance cards will be required at check-in, and we encourage you to find and submit the most recent copy of your card. This includes Medicare and Medicaid as well.
- ✓ If your insurance plan (including Medicaid) requires a referral, please follow up to ensure that it is in our office so that your appointment will not need to be rescheduled.
- ✓ Payment will be required at the time of service for your portion (co-pay and deductible amounts) of the charge.

Please feel free to contact our office with any questions you may have. Our physicians and staff look forward to caring for you and your family.

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Health History Adult

Patient's Name _____ D.O.B. _____

Referring Physician _____

For Women: Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly/Not Sure

Name and location of pharmacy used _____

What are you seeing the doctor for today? _____

List all current medications, including any over-the-counter (OTC) medications or supplements.
(If needed, please provide on separate sheet.)
☐ Not taking any medications

NAME OF MEDICATION	DOSAGE

List any drug allergies or medicines you can not take.
☐ No known drug allergies

NAME OF MEDICATION	TYPE OF REACTION

Do you have a known allergy to any of the following? ☐ None

☐ Latex ☐ Iodine ☐ Tape ☐ Contrast Agents (Dye) ☐ Other (Please describe) _____

Allergies
☐ None
☐ Dust
☐ Moldy Places
☐ Pollen
☐ Cut Grass
☐ Animals
☐ Foods
☐ Smoke/Fumes
☐ Outside in Spring and/or Fall
☐ Outside on Windy Days
☐ Air Conditioning

Allergy Testing
☐ Never Done
☐ Skin/Blood
☐ Negative
☐ Testing Location
_____

Allergy Injections
☐ Never Done
☐ In the Past
☐ Currently

Other Allergies/Problems Not Listed
(Please Describe)
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
_____
_____
_____

Describe Reaction _____
_____
_____

SOLV F PHH ADULT 9/17

Past Health History

Please indicate any diseases or problems that you have had or been diagnosed with by a doctor.

☐ **No Major Illnesses**

1. Childhood Diseases
- ☐ Mumps
- ☐ Measles
- ☐ Chicken Pox
- ☐ Other _____

2. Cancer
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Skin Cancer
- ☐ Leukemia
- ☐ Other _____

3. Congenital (Birth) Problems
- ☐ Down Syndrome
- ☐ Heart Defect
- ☐ Prematurity (# of weeks _____)
- ☐ Other _____

4. Ears
- ☐ Chronic or Frequent Infection
- ☐ Fluid
- ☐ Hearing Loss
- ☐ Vertigo
- ☐ Other _____

5. Nose and Sinuses
- ☐ Chronic Sinusitis
- ☐ Deviated Septum
- ☐ Nasal Polyps
- ☐ Allergies
- ☐ Other _____

6. Mouth and Throat
- ☐ Chronic Tonsillitis
- ☐ Cleft Palate
- ☐ Sleep Apnea
- ☐ Other _____

7. Heart
- ☐ Atrial Fibrillation
- ☐ Chest Pain/Angina
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Pace Maker
- ☐ Other _____

8. Lungs
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Cystic Fibrosis
- ☐ Other _____

9. Digestive
- ☐ GERD/Reflux
- ☐ Hepatitis
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Other _____

10. Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Other _____

11. Neurologic
- ☐ Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Other _____

12. Glands and Hormones
- ☐ Diabetes
- ☐ Thyroid Problem
- ☐ Other _____

13. Blood Disorder
- ☐ Low White Blood Cell Count
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Low Platelets
- ☐ Other _____

14. Immune Disorder
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's
- ☐ CREST
- ☐ HIV
- ☐ Other _____

15. Psychiatric History
- ☐ Depression
- ☐ Anxiety
- ☐ Mania
- ☐ Schizophrenia
- ☐ Other _____

History of any other condition not listed?

Surgeries/Injury

Have you ever had problems with anesthesia (being put to sleep for surgery)? ☐ No ☐ Yes What problem? _____

Indicate any major surgeries (if you choose OTHER please describe).

☐ *No Surgery*

Eyes	☐ Cataract ☐ Eyelid Surgery ☐ Tear Duct ☐ LASIK ☐ Other:
Ears	☐ Tubes ☐ Ear Drum ☐ Mastoid ☐ Other:
Nose	☐ Septoplasty ☐ Rhinoplasty ☐ Sinus Surgery ☐ Other:
Throat	☐ Adenoidectomy ☐ Tonsillectomy ☐ Other:
Neck	☐ Thyroidectomy
Heart	☐ Angioplasty ☐ Bypass ☐ Valve ☐ Stent ☐ Other:
Digestive	☐ Appendectomy ☐ Gallbladder ☐ Hiatal Hernia ☐ Other:
Female Health	☐ Hysterectomy ☐ Ovary Removal ☐ Other:
Other	☐ Any other major surgery:

Serious injury? ☐ No ☐ Yes Please Describe _____

Family History

☐ Family History Unkown

Do any of your BLOOD RELATIVES have a history of:

☐ Problems with Anesthesia
☐ Hearing Loss After Age 20
☐ Heart Problem
☐ Cancer
☐ Other Major Health Problems
Please Describe _____
☐ No Family History Problems Known

Social History

Current Occupation _____ ☐ Retired ☐ Student

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Quit ☐ Yes: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew ☐ Vape

How many per day? _____

When did you start? Age _____ or Year _____ When did you stop? Age _____ or Year _____

Alcohol Use: ☐ Yes ☐ No

How many drinks per week on average? _____

Have you ever been dependent on or addicted to any drugs? ☐ Yes ☐ No

Tests and Immunizations

If you are not sure of the exact date of the test/procedure/immunization (month and day are not necessary), please list at least the year to the best of your recollection.

1. If you are a female patient between the ages of 24-64, when was your most recent cervical cancer screening (pap test)?
   N/A or date _____

2. If you are a female patient between the ages of 42-69, when was your most recent breast cancer screening (mammogram)?
   N/A or date _____

3. If you are a patient between the ages of 50-75, when was your most recent colorectal cancer screening (Colonoscopy, Sigmoidoscopy or FOBT)? N/A or date _____

4. If you are a patient 65 years or older, when was your most recent pneumonia vaccination administered?
   N/A or date _____

5. If you are a patient six months or older, when was your most recent influenza immunization administered?
   N/A or date _____

Patient Signature _____ Date _____