



# Personal Health History Form

Raza Pasha, MD

12121 Richmond Ave, Ste 304  
Houston, Texas, 77082

281-920-5558  
281-920-5568 (fax)

If you have not seen Dr. Pasha before or in the past 6 months, please complete this form in order to update your medical history. This form will be part of your medical record. Upon completion, please sign the last page. All history is held strictly confidentially and is released only with your written permission. Dr. Pasha provides a synopsis of your visit to your referring physicians in order to provide better health care to you.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / 200\_\_\_\_  
Last First MI

Have you seen an ENT physician before?  Yes  No Physicians Name: \_\_\_\_\_

The main problem that brings me to clinic is: \_\_\_\_\_

## Past Medical History

Check any conditions that you have or have had in the past.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cancer – What type? _____ | <input type="checkbox"/> Gastroesophageal Reflux      | <input type="checkbox"/> Migraines            |
| <input type="checkbox"/> AIDS/HIV                  | <input type="checkbox"/> Goiter                       | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> Alcoholism                | <input type="checkbox"/> Gout                         | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Heart disease (heart attack) | <input type="checkbox"/> Pneumonia/Bronchitis |
| <input type="checkbox"/> Anxiety/Panic Attacks     | <input type="checkbox"/> Heart failure                | <input type="checkbox"/> Psychiatric Care     |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Hepatitis or liver disease   | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Bleeding disorder         | <input type="checkbox"/> High cholesterol             | <input type="checkbox"/> Syphilis             |
| <input type="checkbox"/> Chemical Dependency       | <input type="checkbox"/> Immune deficiency            | <input type="checkbox"/> Sleep apnea          |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Kidney disease               | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Lung disease                 | <input type="checkbox"/> Syphilis             |
| <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Measles/Mumps                | <input type="checkbox"/> Thyroid disorder     |
| <input type="checkbox"/> Epilepsy (seizure)        |   | <input type="checkbox"/> Tuberculosis         |

Do you have any other medical conditions? \_\_\_\_\_

## Past Surgical History

Check any ENT procedures you have had in the past.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Adenoidectomy           | <input type="checkbox"/> Other Ear Surgery | <input type="checkbox"/> Sinus Surgery              |
| <input type="checkbox"/> Cancer Surgery          | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Tonsillectomy              |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Rhinoplasty       | <input type="checkbox"/> UP3 (sleep apnea surgery)  |
| <input type="checkbox"/> Ear (Myringotomy) Tubes | <input type="checkbox"/> Septoplasty       | <input type="checkbox"/> Voice Box (Larynx) Surgery |
| <input type="checkbox"/> Mastoidectomy           |  |   |

Have you had any other surgeries or procedures?  Yes  No

## Medications and Medicine Allergies

List all prescription and non-prescription medications you currently take:  None

Medication	Strength	Frequency	Medication	Strength	Frequency
Medication	Strength	Frequency	Medication	Strength	Frequency
Medication	Strength	Frequency	Medication	Strength	Frequency
Medication	Strength	Frequency	Medication	Strength	Frequency

Do you take aspirin?  Yes  No

What medications are you allergic or have had bad reactions?  None

Medication	Medication	Medication
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### Social History

Do/have you smoked?  Yes  No Did you quit?  Yes  No How long ago? \_\_\_\_\_

If so, how much and how long have/did you smoke? \_\_\_\_\_ pack(s)/day for \_\_\_\_\_ year(s)

Do/have you drink alcohol?  Yes  No Did you quit?  Yes  No How long ago? \_\_\_\_\_

If so, how much do/did you drink? \_\_\_\_\_

Have you or currently use any "street drugs"?  Yes  No What type? \_\_\_\_\_

### Family History

Does anyone in your family have any of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer – What type? _____ | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Thyroid disease          |
| <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Problems with anesthesia |
| <input type="checkbox"/> Blood disorders           | <input type="checkbox"/> Hearing Loss  |   |
| <input type="checkbox"/> Cystic fibrosis           |  |   |

Are there any other diseases that run in your family? \_\_\_\_\_

### Birth History (Patients under 12 years of age)

What kind of delivery did you have?  vaginal delivery  cesarean delivery  
 full term  premature \_\_\_\_\_ week(s)  late \_\_\_\_\_ week(s)

Were there any complications during or after delivery?  none

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Intensive Care Stay           | <input type="checkbox"/> Jaundice         | <input type="checkbox"/> Meningitis         | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Intubated (breathing machine) | <input type="checkbox"/> Low birth weight | <input type="checkbox"/> Neonatal Infection |                                       |

Are your child's immunizations up-to-date?  yes  no  scheduled

## Review of Systems

Have you had any of the following in the last 48 hours?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Changes in vision       | <input type="checkbox"/> Fever (>100.5°)      | <input type="checkbox"/> Numbness or weakness    |
| <input type="checkbox"/> Diarrhea/Constipation   | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Problems urinating      |
| <input type="checkbox"/> Difficulty in breathing | <input type="checkbox"/> Muscle Aches         | <input type="checkbox"/> Skin changes            |
| <input type="checkbox"/> Feeling anxious         | <input type="checkbox"/> Nausea or vomiting   | <input type="checkbox"/> Unexplained weight loss |

Have you had any of the following in regards to your ears?  No

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Ear drainage                 | <input type="checkbox"/> Ear fullness or pressure |
| <input type="checkbox"/> Ear pain          | <input type="checkbox"/> Noise or ringing in the ears | <input type="checkbox"/> Worsening hearing        |

Have you had any of the following in regards to your nose and sinus?  No

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Facial pain   | <input type="checkbox"/> Hay Fever/Allergies        | <input type="checkbox"/> Headaches           |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Nasal blockage             | <input type="checkbox"/> Nose bleeds         |
| <input type="checkbox"/> Runny Nose    | <input type="checkbox"/> Pressure in the head/sinus | <input type="checkbox"/> Watery eyes/itching |

Have you had any of the following in regards to your throat?  No

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bad breath     | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Dry mouth          |
| <input type="checkbox"/> Gagging        | <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Heartburn          |
| <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Post nasal drip       | <input type="checkbox"/> Pain on swallowing |

Do you have problems with any of the following?  No

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Daytime tiredness | <input type="checkbox"/> Gasping at night        | <input type="checkbox"/> Mouth breathing |
| <input type="checkbox"/> Snoring           | <input type="checkbox"/> Stop breathing at night |  |

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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the office staff responsible for errors or omissions that I may have made in completing this form.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_ - \_\_\_\_ - 200\_\_  
Date

\_\_\_\_\_  
Physician

\_\_\_\_ - \_\_\_\_ - 200\_\_  
Date