ALLIANCE
GENERAL HISTORY FORM

PATIENT LEGAL NAME: _____ **DATE OF BIRTH:** _____

HOW WERE YOU REFERRED TO OUR PRACTICE? _____

☐ If physician, name: _____

☐ Do you know anyone who goes to Alliance? If so, name: _____

HAVE YOU SEEN US ON... ☐ Social media ☐ The web ☐ Advertisement ☐ Other: _____

WHAT BROUGHT YOU TO ALLIANCE? _____

WOULD YOU LIKE TO DISCUSS ANY OF THE TOPICS BELOW AT YOUR VISIT? ☐ **Yes** ☐ **No**

☐ Allergy/Sinus ☐ Sleep ☐ Cosmetics or Injectables ☐ Facial Trauma ☐ Voice swallowing ☐ Other: _____

MEDICATION ALLERGIES ☐ No known drug allergies

List any drug reactions and side effects experienced (e.g. shortness of breath, swelling, itching, hives, nausea, vomiting, diarrhea)

_____

LIST ALL MEDICATIONS YOU ARE TAKING OR ATTACH LIST (Prescription & over-the-counter) ☐ No medication

MEDICATION	DOSAGE	HOW OFTEN	MEDICATION	DOSAGE	HOW OFTEN

FAMILY HISTORY

☐ Bleeding disorder
☐ Anesthesia reaction
☐ Heart disease
☐ High cholesterol
☐ High blood pressure
☐ Hearing loss
☐ Diabetes
☐ Asthma
☐ CVA (stroke)
☐ Cancer – type: _____
☐ Other: _____

MEDICAL HISTORY **Have you ever been diagnosed with any of the following?** ☐ No medical history

☐ Bleeding disorder
☐ Anesthesia reaction
☐ Heart disease
☐ High cholesterol
☐ High blood pressure
☐ Gastroesophageal reflux
☐ Diabetes
☐ Asthma
☐ Thyroid disease
☐ Sleep apnea
☐ Sickle cell disease
☐ Hepatitis
☐ Tuberculosis
☐ HIV or AIDS
☐ Cancer – type: _____

SURGICAL ENT HISTORY Please check next to any EAR, NOSE, or THROAT SURGERIES ☐ No ENT surgical history

NOSE
☐ Septoplasty (deviated septum) ☐ Rhinoplasty (nose reconstruction) ☐ Turbinate reduction
☐ Nasal polyp removal ☐ Nasal fracture repair

THROAT
☐ Tonsillectomy ☐ Adenoidectomy ☐ Tracheostomy ☐ Excision of neck mass
☐ Tonsil / palate surgery ☐ Laryngoscopy

EAR
☐ Ear tubes ☐ Tympanoplasty (ear drum) ☐ Mastoidectomy (mastoid)

SINUS
☐ Balloon sinuplasty ☐ Traditional sinus surgery

PLEASE LIST OTHER PAST SURGERIES:

_____

201 N. MAYFAIR RD, SUITE 515, MILWAUKEE, WI 53226
17000 W. NORTH AVE, SUITE 105E, BROOKFIELD, WI 53005
9969 S. 27TH STREET, 2ND FLOOR, FRANKLIN, WI 53132

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FAX: (414) 727-0920

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SOCIAL HISTORY

- ☐ Child/Student
- ☐ Employed
- ☐ Retired
- ☐ Unemployed
- ☐ Disabled

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Tobacco use?	☐ Yes	☐ No	☐ Former	
Exposed to second hand smoke?	☐ Yes	☐ No		
Alcohol consumption?	☐ Often	☐ None	☐ Occasional	
Drug use – marijuana, heroin, cocaine?	☐ Yes	☐ No		
Do you have a pacemaker or defibrillator?	☐ Yes	☐ No		

REVIEW OF SYMPTOMS

GENERAL HEALTH
☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weight loss / gain ☐ Trouble sleeping ☐ Loss of appetite

EYE
☐ Change in vision ☐ Itchy / watery eyes ☐ Light sensitivity ☐ Double vision

EAR
☐ Drainage ☐ Hearing loss ☐ Infections ☐ Itchiness ☐ Ear pain ☐ Tinnitus (ringing in ears)

BLOOD/LYMPH NODES
☐ Easy bleeding / bruising ☐ Anemia

NOSE & SINUS
☐ Congestion / blockage ☐ Facial pain / pressure ☐ Difficulty breathing ☐ Nose bleeds
☐ Sneezing ☐ Stuffy nose ☐ Runny nose ☐ Post nasal drainage ☐ Sinus infections

MOUTH & THROAT
☐ Difficulty swallowing ☐ Painful swallowing ☐ Sleep apnea ☐ Snoring ☐ Sore throat
☐ Throat clearing ☐ Hoarseness ☐ Sores / ulcers in mouth ☐ Coughing blood ☐ Voice changes

GLANDS & HORMONES
☐ Heat intolerance ☐ Cold intolerance ☐ Swollen glands

CARDIOVASCULAR
☐ Heart murmur ☐ Chest pain ☐ Swelling of ankles / edema ☐ Blacking out
☐ Irregular heartbeat ☐ Palpitations

RESPIRATORY
☐ Cough ☐ Frequent colds/bronchitis ☐ History of pneumonia ☐ Shortness of breath
☐ Wheezing ☐ Difficulty breathing

ALLERGY
☐ Food allergies ☐ Insect allergies ☐ Seasonal allergies ☐ Hay fever ☐ Drug allergies

MUSCULOSKELETAL
☐ Muscle aches / cramps ☐ Joint swelling or pain ☐ Facial muscle weakness

STOMACH
☐ Abdominal pain ☐ Diarrhea ☐ Heartburn / indigestion ☐ Nausea / vomiting

BRAIN OR NERVOUS SYSTEM
☐ Headache ☐ Seizures ☐ Dizziness ☐ Numbness ☐ Nerve pain

SKIN
☐ Itchy skin/ pruritis ☐ Rash ☐ Hives / welts ☐ Dry skin ☐ Contact Allergy

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PEDIATRIC HISTORY

COMPLETE IF PATIENT IS UNDER 18

Was patient born prematurely? (# of wks ___) ☐ Yes ☐ No
Require intubation or oxygen after delivery? ☐ Yes ☐ No
Was child breastfed? (if so, how long? _____) ☐ Yes ☐ No
History of eczema or food intolerance as kid? ☐ Yes ☐ No
Any feeding/dietary problems? ☐ Yes ☐ No
Any difficulties with growth or weight gain? ☐ Yes ☐ No

Does child have noisy breathing? ☐ Yes ☐ No
Family history of alcohol, tobacco, or drug use? ☐ Yes ☐ No
Has your child had any of the following delays?
☐ Walking ☐ Learning ☐ Talking
Child lives with:
☐ Mother ☐ Father ☐ Both ☐ Other

IMMUNIZATIONS

Are your immunizations current? ☐ Yes ☐ No
Do you receive annual flu vaccines? ☐ Yes ☐ No

FEMALES ONLY

Chance of pregnancy? ☐ Yes ☐ No
Currently breastfeeding? ☐ Yes ☐ No

PATIENT/GUARDIAN SIGNATURE*: _____ DATE: _____

PHYSICIAN REVIEW: _____ DATE: _____

* BY SIGNING ABOVE YOU ARE CONFIRMING THAT I HAVE READ AND AGREED TO ALLIANCE'S FINANCIAL POLICIES

☐ I HAVE REQUESTED AND RECEIVED A COPY OF ALLIANCE'S FINANCIAL POLICIES (PLEASE CHECK)

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