

**Date:** \_\_\_\_\_

*Patient Medical Information*

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**TYPE OF REACTION:** \_\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_

For Children under 18, are immunizations up to date?    Y    N

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

\*Height & weight is needed to schedule certain tests.

<b>Current Medications and Dosage, include Over the Counter Medications &amp; Supplements:</b>		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

General Medical Information

Please circle all that apply

**Medical History**

- |              |                  |                  |                         |
|--------------|------------------|------------------|-------------------------|
| Hypertension | Heart Disease    | High Cholesterol | Liver Disease/Hepatitis |
| Stroke       | Seizure Disorder | Diabetes         | Thyroid Disease         |
| Acid Reflux  | Kidney Disease   | Arthritis        | Tuberculosis            |
| HIV          | Trauma/Accident  | Asthma           | Pacemaker/Defibrillator |
| Stent        | Metal implant    | Lung Disease     |                         |

**Cancer**

(Type/treatment): \_\_\_\_\_

Other: \_\_\_\_\_

**Surgical History**

- |               |               |                   |               |
|---------------|---------------|-------------------|---------------|
| Tonsillectomy | Adenoidectomy | Sinus Surgery     | Nasal Surgery |
| Thyroidectomy | Ear Surgery   | Appendectomy      | Heart Surgery |
| Hysterectomy  | Gallbladder   | Laryngeal Surgery |               |

Other: \_\_\_\_\_

Have you or any family member (*immediate or extended*) ever had problems with anesthesia?  
 Yes      No              (Check One)    You \_\_\_\_\_              Family Member \_\_\_\_\_

Have you or any family member (*immediate or extended*) ever had bleeding or clotting problems?  
 Yes      No              (Check One)    You \_\_\_\_\_              Family Member \_\_\_\_\_

Have you ever had an injury to the eye caused by metal?  
 Yes      No

Are you allergic to Iodine or IVP dye?  
 Yes      No

**Family Medical History:**

Father: \_\_\_\_\_  
 Mother: \_\_\_\_\_  
 Siblings: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Review of Current Systems: *Circle all that apply:***

**Constitutional:**

fever, weakness, fatigue, weight loss

**Eyes:**

visual changes, pain, redness, tearing

**ENT:**

change in hearing

discharge, ringing, dizziness or pain

head colds, nosebleeds, sore throat, drainage

**Mouth:**

redness or soreness of gums, lips or oral mucosa

**Cardiovascular:**

chest pain, palpitations

leg swelling or pain

**Respiratory:**

shortness of breath

cough or sputum production

**Gastrointestinal:**

loss of appetite

nausea or vomiting

constipation or diarrhea

abdominal pain

**Genitourinary:**

frequent or painful urination

blood in urine

**Musculoskeletal:**

joint pain, stiffness or muscle pain

cramping, swelling, motor activity limitation

**Integumentary:**

changes in skin, hair, nails or moles

**Neurological:**

headaches, blackouts, lightheadedness

weakness, paralysis, tingling, tremors

memory loss

**Psychiatric:**

nervousness, mood changes, depression

insomnia or nightmares

**Endocrine:**

heat or cold intolerance

increased sweating or thirst

**Hematologic/Lymphatic:**

easy bleeding/bruising

swollen glands

**Allergic/Immunologic**

recurrent infections or hypersensitivity

**Pain:**

pain

**Social History:**

Do you have passive smoke exposure? Yes No  
 Do you or have you use(d) tobacco? Yes No  
 What type? Cigarettes Cigars Pipe Chewing tobacco  
 If yes, how much per day? \_\_\_\_\_ Number of years \_\_\_\_\_  
 Have you quit? Yes No What year? \_\_\_\_\_  
 If you still smoke, are you motivated to quit? \_\_\_\_\_  
 If you still smoke, have you tried to quit? \_\_\_\_\_  
 Do you drink alcohol? Yes No How much in one week? \_\_\_\_\_  
 Do you use illicit drugs? Yes No How much per day? \_\_\_\_\_  
 Do you use caffeine? Yes No How much per day? \_\_\_\_\_

Occupation: \_\_\_\_\_

Are you or have you been exposed to prolonged excess noise? Yes No

**ENT Specific Questionnaire:**

- I am interested in learning more about hearing loss and hearing aids.
- I am interested in learning more about nasal blockage/congestion.
- I am interested in learning more about treatments for snoring and sleep apnea.

**I certify that the above provided information is correct. All confidential information contained herein is included as a part of your medical record and will only be released in accordance with HIPAA (Health Insurance Portability & Accountability Act.)**

\_\_\_\_\_  
**Patient or Responsible Party Signature**

\_\_\_\_\_  
 Physician

Date \_\_\_\_\_

Date \_\_\_\_\_