

ADVANCED EAR, NOSE, & THROAT SPECIALISTS

PATIENT NAME: _____ AGE: _____ DATE: _____

NAME OF PRIMARY PHYSICIAN: _____

NAME OF REFERRING PHYSICIAN/SPECIALIST: _____

REASON FOR TODAY'S VISIT: _____

IS VISIT DUE TO AN ACCIDENT? _____ DATE OF ACCIDENT? _____ ARE YOU PREGNANT? _____

PATIENT HISTORY

Have you ever had, or do you have...

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Heart Disease/Failure | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Sexually Transmitted Dx |
| <input type="checkbox"/> Nasal Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dizziness/ Meniere's Dx | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Anemia | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine Headache | _____ |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Liver infection/hepatitis | <input type="checkbox"/> Kidney stones | |

SURGERIES, INJURIES, AND MAJOR HOSPITALIZATIONS (INCLUDE DATES):

CURRENT MEDICATIONS (YOU MAY ATTACH YOUR MEDICATION LIST)? (Please list all)

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

MEDICATION ALLERGIES? YES NO IF YES, WHICH MEDICATIONS AND TYPE OF REACTION?

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |

FAMILY HISTORY

Has anyone in your immediate family (Parents, Siblings or Children) had...

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> COPD/ Emphysema | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Dizziness/Meniere's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Angina/ heart attack | |

SOCIAL HISTORY

Occupation: _____ If retired, former occupation: _____

Military Service: Yes/ No If yes, # of years _____

Noise Exposure: Yes/ No If yes, type? _____

Do you... (please check or circle all that apply)

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Use Alcohol | <input type="checkbox"/> Use Drugs |
| <input type="checkbox"/> Use Tobacco currently or recently quit? When did you quit? _____ # years _____ #packs _____ | |

REVIEWED BY: _____ DATE: _____