

## 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: \_\_\_\_\_

## ADVANCED EAR, NOSE, & THROAT SPECIALISTS

### PATIENT REVIEW OF SYSTEMS

Please check all the symptoms you are CURRENTLY experiencing:

<b>EYES</b>	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Painful Eyes	<input type="checkbox"/> Sensitivity to light
	<input type="checkbox"/> Itchy, watery eyes	<input type="checkbox"/> Other: _____	
<b>EARS, NOSE, THROAT AND MOUTH</b>	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Blocked nose	<input type="checkbox"/> Post nasal drip
	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Painful swallowing	<input type="checkbox"/> Pressure/fullness in ears
	<input type="checkbox"/> Facial pain/pressure	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Hoarseness/Change of voice
	<input type="checkbox"/> Pain in _____	<input type="checkbox"/> Lump in neck	<input type="checkbox"/> Other: _____
<b>CARDIOVASCULAR (HEART)</b>	<input type="checkbox"/> Palpitations/ Fluttering of heart		<input type="checkbox"/> Pain in chest
	<input type="checkbox"/> Shortness of breath while exercising		<input type="checkbox"/> Other: _____
<b>RESPIRATORY (LUNGS)</b>	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath
	<input type="checkbox"/> Blood from throat	<input type="checkbox"/> Other: _____	
<b>GASTROINTESTINAL (STOMACH)</b>	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Hiatal hernia	<input type="checkbox"/> Abdominal pain
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Other: _____
<b>GENITOURINARY</b>	<input type="checkbox"/> Pain when urinating	<input type="checkbox"/> Urination at Night	<input type="checkbox"/> Pregnancy
	<input type="checkbox"/> Hesitation when urinating		<input type="checkbox"/> Other: _____
<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> Soreness	<input type="checkbox"/> Weakness	<input type="checkbox"/> Cramping
	<input type="checkbox"/> Other: _____		
<b>INTEGUMENTARY (SKIN)</b>	<input type="checkbox"/> Itchy skin	<input type="checkbox"/> Lesions on Skin	<input type="checkbox"/> Bleeding
	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Other: _____	
<b>NEUROLOGICAL (NERVES)</b>	<input type="checkbox"/> Headaches	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Dizziness/ Vertigo
	<input type="checkbox"/> Abnormal movements	<input type="checkbox"/> Imbalance	<input type="checkbox"/> Other: _____
<b>PSYCHIATRIC</b>	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Situational Stress	<input type="checkbox"/> Depression
<b>ENDOCRINE</b>	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Hair loss/ growth	<input type="checkbox"/> Heat/cold sensitivity
	<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Other: _____	
<b>HEMATOLOGIC/ LYMPH NODES</b>	<input type="checkbox"/> Bleeding easily	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Swollen lymph nodes
	<input type="checkbox"/> Other: _____		Location: _____
<b>ANESTHESIA</b>	<input type="checkbox"/> NEVER had anesthesia	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> NO history of anesthesia reactions
	<input type="checkbox"/> Chipped/loose teeth	<input type="checkbox"/> Difficult airway	<input type="checkbox"/> Malignant hyperthermia

\_\_\_\_\_  
PATIENT OR PARENT/GUARDIAN

\_\_\_\_\_  
DATE