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...

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

□ Hearing loss	□ COPD/ Emphysema	□ High blood pressure	□ Asthma
□ Dizziness/Meniere's	□ Diabetes	□ Birth Defects	□ Kidney Disease
□ Thyroid Problem	□ Stroke	□ Bleeding disorder	□ Cancer:_____
□ Migraine Headache	□ Epilepsy / Seizures	□ 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)

□ Use Alcohol □ Use Drugs
□ Use Tobacco currently or recently quit? When did you quit?_____ # years _____#packs_____

REVIEWED BY:_____ **DATE:**_____

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PATIENT REVIEW OF SYSTEMS

Please check all the symptoms you are CURRENTLY experiencing:

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

_____ _____

PATIENT OR PARENT/GUARDIAN **DATE**