Diseases of the Ears, Nose and Throat, Inc.

Medical History

Patient Name: _____Today's Date_____

DOB: ____/____/_____ Age: _____ Referring Physician: _____

Reason for your visit: _____

Preferred Pharmacy_____ Pharmacy Phone #_____

Patient Medications

Please list ALL MEDICATIONS, (including over-the-counter) that you are currently taking below:

☐ I am not currently taking any medications (including over-the-counter, herbals, etc.)

Name:	Dose:	Times a Day:	Reason you take it:

Patient Medication Allergies

Are you allergic to latex? Yes __ No __

Are you allergic to medical tape? Yes __ No __

Do you have any known drug allergies? Yes __ No __

If yes, please list medications you are allergic to below:

Medication Name	Reaction

Past Surgical History

☐ tonsil ☐ ear tubes ☐ ear surgery ☐ nasal/sinus surgery ☐ thyroid ☐ (*see list)*

Other Surgeries	Year	Comments

Past Medical History

	Allergies/Hayfever		Ear Infections		High Blood Pressure
	Anemia		Emphysema		Immune System Disorder
	Anxiety Disorder		GERD/Reflux		Migraines
	Asthma		Headaches		Neurologic Disorder
	Bleeding Disorder		Hearing Loss		Sleep Disorder
	Cancer		Heart Attack (MI)		Speech Delay
	COPD		Heart Disease		Stroke
	Depression		Heart Problems		Thyroid Problems
	Diabetes		Hepatitis		
	Dizziness or fainting		High Cholesterol		

Patient Family History

Disease	Family Member (Please indicate maternal or paternal)	Comments
Heart Disease		
Asthma		
Diabetes		
COPD		
Hepatitis		
Stroke		
Bleeding Problems		
High Blood Pressure		
Other:		

Patient Social History

1. Do you ever drink alcohol? Yes __ No __
   1a. If Yes, how often? ☐ Occasionally ☐ Weekly ☐ Daily
2. Do you smoke? Yes __ No __
   2a. If Yes, __ packs a day for __ years ?
3. Are you exposed to second hand smoke? Yes __ No __
4. Do you use any other tobacco products? Yes __ No __
5. What is/was your occupation: _____
6. Have you been exposed to excessive noise (explain)? _____

Patient Name_____ DOB: _____

Review of Systems

Please check all problems that you CURRENTLY have OR Please check "NONE"

Constitutional: ☐ none
☐ fatigue ☐ fever ☐ significant weight loss ☐ significant weight gain

Eyes: ☐ none
☐ blurred vision ☐ double vision ☐ itching ☐ burning ☐ eye pain

Ear: ☐none
☐ difficulty hearing ☐ ear pain ☐ vertigo ☐ tinnitus ☐ ears feel pressured ☐ discharge from ears

Nose: ☐none
☐ frequent nosebleeds ☐ nasal congestion ☐ nose/sinus problems ☐ rhinorrhea (runny nose)
☐ sinus pressure ☐ blockage/obstruction

Mouth/Throat: ☐none
☐ sore throat ☐ bleeding gums ☐ snoring ☐ dry mouth ☐ oral abnormalities ☐ mouth ulcer
☐ teeth abnormalities ☐ difficulty swallowing ☐ post nasal drip ☐ hoarseness ☐ mouth breathing

Neuro: ☐ none
☐ fainting ☐ frequent headaches ☐ seizures ☐ numbness ☐ weakness ☐ migraines ☐ restless legs
☐ loss of consciousness

Cardiovascular: ☐ none
☐ chest pain ☐ heart murmur ☐ dyspnea (shortness of breath) on exertion ☐ edema (swelling)
☐ palpitations ☐ light headed on standing

Respiratory: ☐ none
☐ wheezing ☐ shortness of breath ☐ hemoptysis (coughing up blood) ☐ sputum production
☐ sleep apnea

GI: ☐ none
☐ vomiting ☐ heartburn ☐ painful swallowing ☐ no appetite ☐ increased appetite

Hematologic/Lymphatic: ☐ none
☐ swollen glands ☐ easy bruising ☐ excessive bleeding

Psychiatric: ☐ none
☐ anxiety ☐ depression ☐ restless sleep ☐ other_____

Urinary: ☐ none
☐ urinary retention ☐ frequent urination ☐ difficult urination ☐ hematuria **(**bloody urine)
☐ incontinence ☐ painful urination

Musculoskeletal: ☐ none
☐ joint pain ☐ muscle aches

Skin: ☐ none
☐ rash ☐ itching ☐ dry skin ☐ growth/lesions

Endocrine: ☐ none
☐ increased thirst ☐ increased drinking ☐ increased hunger ☐ diabetes

Allergic/Immuno: ☐ none
☐ sneezing ☐ runny nose

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
(signature if over 18) **(Date)**

If you are not the patient:

_____ _____
(please print your name) **(Relationship to Patient)**