



Patient Name: _____

Date of Birth: _____

What is the reason for today's visit?

Has the patient had any recent imaging done for the reason for visit? Yes No

IF YES, please describe: _____

Has the patient seen another Ear, Nose, and Throat MD? Yes No

If YES, please list the physician name and when: _____

Patient's Height: _____ **Patient's Weight:** _____

Primary Care MD _____

Preferred Pharmacy name: _____

Preferred Pharmacy address: _____

Is the patient currently taking any medications? Yes No

If yes, please list all current medications and dosages (INCLUDING NASAL SPRAYS, VITAMINS, SUPPLEMENTS, and EYEDROPS).

Is the patient allergic to any medications? Yes No

If yes, please list medication(s) and the reaction(s)

MEDICAL HISTORY:

Does the patient have, or have they ever had any of the following?

- | | | | | | |
|-------------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headache/Migraine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clotting Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease/Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizure Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| COPD/Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sleep Apnea/Snoring | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes Mellitus | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| GERD/Acid Reflux | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Depression/Anxiety | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- Other, please explain:** _____
- History of cancer, please explain _____
- Thyroid problem, please explain _____
- Any other medical problems not listed?** Please explain _____

Has the patient ever had any surgeries? Please check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Sinus surgery | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Septoplasty | <input type="checkbox"/> Tonsillectomy |
- Cancer surgery, please explain _____
- Other ear surgery, please explain _____
- Heart surgery, please explain _____
- Lung surgery, please explain _____
- Neck surgery, please explain _____
- Spine surgery please explain _____
- Other Surgery, please explain _____

FAMILY HISTORY:

	Alive	Deceased	N/A	Medical History: (Heart disease, Diabetes, Cancer, Hearing loss, Thyroid disorder)
Mother				
Father				
Brother(s)				
Sister(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

- Any family history of bleeding disorder?** Yes No IF YES, please describe: _____
- Any family history of problems with anesthesia?** Yes No IF YES, please describe: _____

SOCIAL HISTORY:

Tobacco use: Current every day smoker, packs per day _____
 Current someday smoker, packs per week _____
 Former Smoker
 Quit Date: _____ Packs per day: _____
 Never Smoked

Smokeless Tobacco (i.e. Chewing Tobacco, Vaping): Current use
 Used in the past
 Quit Date: _____ Frequency: _____
 Never

Alcohol use: Yes No
 If yes, how many drinks per week? _____

What is the patient's marital status? Married/Civil Union Single Widowed

What is the patient's current employment status?

Student Unemployed Employed Homemaker Retired

If employed, what kind of job does the patient have? _____

For Minor patients:

Does the patient attend Daycare or school? Yes No

Who does the patient live with? Parents Siblings Other _____

REVIEW OF SYSTEMS:

Besides the patients known past medical problems-	YES	NO
Are there any <u>new psychiatric</u> issues today, such as depression or anxiety?		
Are there any <u>new cardiac issues</u> today, such as chest pain or heart palpitations?		
Are there any <u>new gastric or bowel issues</u> today, such as heartburn, indigestion or diarrhea?		
Are there any <u>new skin issues</u> today, such as rash or itching?		
Are there any <u>new hormonal issues</u> today, such as heat intolerance, unexplained weight change or blood sugar problems?		
Are there any <u>new neurological issues</u> , today, such as new headache or unsteadiness?		
Are there any <u>new eye issues</u> today, such as new vision or tearing problems?		
Are there any <u>new lung</u> issues today, such as difficulty breathing or cough?		
Are there any <u>new bleeding issues</u> today, such as unexplained bruising or bleeding?		
Are there any <u>new bladder/kidney issues</u> today, such as difficulty urinating or pain?		
Are there any <u>new joint or muscle issues</u> today, such as joint stiffness or swelling?		
Are there any new problems with <u>fatigue or malaise</u> today?		