MASSACHUSETTS EYE AND EAR

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	☐ Yes	☐ No	Headache/Migraine	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Clotting Disorder	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Liver Disease/Hepatitis	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
COPD/Emphysema	☐ Yes	☐ No	Sleep Apnea/Snoring	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
GERD/Acid Reflux	☐ Yes	☐ No	Depression/Anxiety	☐ Yes	☐ 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.***

☐ Adenoidectomy	☐ Sinus surgery	☐ Thyroidectomy
☐ Ear tubes	☐ Septoplasty	☐ 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? _____

For patients < 18 years old: Does the patient attend **daycare or school**? ☐ Yes ☐ No

For patients < 18 years old: **Patient lives with**: ☐ Parents ☐ Siblings ☐ Other_____

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

What is the patient's current employment status?

☐ Student ☐ Unemployed ☐ Employed ☐ Homemaker ☐ Retired

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

REVIEW OF SYSTEMS:

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