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
Arthritis	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No
Clotting disorder	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Diabetes mellitus	☐ Yes	☐ No
GERD	☐ Yes	☐ No
Headache/Migraine	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Seizure disorder	☐ Yes	☐ No
Sleep apnea/snoring	☐ Yes	☐ No
Stroke	☐ 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
☐ Ear tubes
☐ Sinus surgery
☐ Septoplasty
☐ Thyroidectomy
☐ 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
☐ Current someday smoker
☐ 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 **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 **<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?		