

PATIENT NAME _____ Date of Birth _____ Today's Date _____

The following list reviews a number of health problems. Please place a check mark if you or your family has experienced any of these health problems.

	Problem	Patient	Family	Please Explain
General	Fever/chills Fatigue Weight change Headaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Eye	Change in vision Glasses/Contacts Cataracts or glaucoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Ear, Nose, Throat	Nosebleeds Sore throat or tonsillitis Hoarseness Swallowing difficulty Hearing problems Ear infections Dizziness or vertigo Sinus or nose problems Tinnitus (ears ringing) Loud snoring Daytime sleepiness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Allergy	Seasonal hayfever Food reactions Allergy shots Latex reactions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Respiratory	Asthma, wheezing Chronic cough Emphysema or COPD Bronchitis or pneumonia Tuberculosis (TB)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Cardiovascular	Chest pain or palpitations Angina or heart attack Heart disease or surgery High blood pressure Coronary artery disease High cholesterol/ triglycerides Heart murmur or rheumatic fever Shortness of breath	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
GI	Acid reflux / heartburn Peptic ulcer disease Hiatal hernia Constipation Diarrhea / Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
GU	Prostate problems Difficulty urinating GYN problems Could you be pregnant? Kidney disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Musculoskeletal	Arthritis problems Back or neck problems Muscle weakness or pain Gout Physical limitations or prosthesis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Skin	Hives or rashes Eczema Breast disease Skin cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Neurological/ Psychiatric	Stroke Seizures, convulsions, fainting, epilepsy Headaches or migraines Depression or anxiety Paralysis Neurologic or psychiatric problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Endocrine	Diabetes, low or high blood sugar Thyroid problems Pituitary or adrenal problems Excessive thirst	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Immunologic/ Hematologic	Bleeding or bruising Anemia problems Enlarged lymph nodes HIV / AIDS Blood transfusion Phlebitis (blood clots) Hepatitis or jaundice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

PATIENT NAME _____ Date of Birth _____ Today's Date _____

Your current medication(s), medication allergies, and past health problems are an important part of your diagnosis and treatment plan. Please try to answer all questions fully.

What problem are you being seen for today? _____

Medications:

Please list your current medications.

What **medication allergies** do you have? Please include the type of reaction you experienced.

Have you ever smoked? Yes _____ No _____ If Yes, how many packs a day? _____ For how many years? _____

Do you smoke/chew tobacco now? Yes _____ No _____ If you quit, date/year you quit? _____

Do you drink alcohol on a regular basis? Yes _____ No _____ If Yes, how many drinks per day or week? _____

Do you use any other "recreational drugs"? Yes _____ No _____

Please list medical problems currently being treated by another physician (i.e. hypertension, heart attack, emphysema etc.):

Please list any surgeries (and approximate dates if you remember) you have had in the past:

Have you had any adverse reactions to anesthesia? If so, explain: _____

Have you or anyone in your family had cancer? If so, explain: _____

Have you received radiation in the past? Yes _____ No _____

Have you seen any other ENT physician for this current problem? If yes, when and where? _____

Please list any other information you think your physician should know about your health.

