Ear, Nose & Throat Center, LLP

PATIENT NAME: DOB: DATE:

REASON FOR VISIT: ALLERGIES TO MEDICATIONS:

PAST MEDICAL HISTORY	**Y**	**N**	**IF YES, EXPLAIN**	*FAMILY HISTORY*	**Y**	**N**	*RELATIVE RELATIONSHIP*
SEASONAL ALLERGIES				ANESTHESIA PROBLEMS			
ASTHMA				ASTHMA			
BLEEDING DISORDER				BLEEDING DISORDER			
CANCER				CANCER			
DIABETES				DIABETES			
ESOPHAGEAL REFLUX				HEART DISEASE			
HEART DISEASE				HEARING LOSS			
HIGH BLOOD PRESSURE				THYROID DISORDER			
LUNG DISEASE							
STROKE							
THYROID DISORDER							

OTHER MEDICAL PROBLEMS:

DID YOU HAVE YOUR FLU SHOT: IF YES WHEN:

PATIENT SOCIAL HISTORY

FOR ADULT PATIENTS	**Y**	**N**		**FOR PEDIATRIC'S**	**Y**	**N**	
DO YOU OR DID YOU SMOKE				DAYCARE			
YEAR STARTED:				STUDENT			
HOW MANY PACKS PER DAY			IF QUIT WHAT YEAR?	IS THERE A SMOKER IN THE HOME?			
DO YOU DRINK ALCOHOL?			DRINKS PER WEEK:	SIBLINGS:			AGES:
DO YOU DRINK COFFEE?			CUPS PER DAY:				

REVIEW OF SYSTEMS	**Y**	**N**	***PLEASE INDICATE IF YOU HAVE HAD THE FOLLOWING***	**Y**	**N**	
SHORTNESS OF BREATH			COUGH			
CHEST PAIN			PALPITATIONS			
BLURRED VISION			WATERY/ITCHY EYES			
ABDOMINAL PAIN			HEARTBURN			
FATIGUE			HEADACHE			
CHILLS			NIGHT SWEATS			
WEIGHT LOSS			WEIGHT GAIN			
BLEEDING PROBLEMS			SWOLLEN GLANDS			
JOINT ACHES			BACK PAIN			
PAINFUL URINATION			FREQUENT URINATION			
RASH/HIVES			ITCHING			
DEPRESSION			ANXIETY/PANIC DISORDER			

HAVE YOU HAD 2 OR MORE FALLS IN THE PAST YEAR? **YES** **NO**

HAVE YOU HAD ANY FALLS IN THE PAST YEAR RESULTING IN INJURY? **YES** **NO**

**** PLEASE LIST ANY **OPERATIONS, HOSPITALIZATIONS** YOU HAVE EVER HAD (INCLUDE TONSILS & ADENOIDS), AND THE YEAR:

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**** PLEASE LIST **ANY CURRENT MEDICATIONS** (INCLUDE AMOUNTS, TIMES PER DAY). PLEASE INCLUDE ASPIRIN, ANTACIDS, VITAMINS, BIRTH CONTROL, HERBAL SUPPLEMENTS, HORMOME REPLACEMENT, NASAL SPRAYS, and COLD/SINUS/ALLERGY MEDICATIONS:

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