

Name: _____ **D.O.B.:** _____

Date: _____

Were you referred by another doctor? DR _____

Do you have a family/primary care doctor? DR _____

QUESTIONS ABOUT TODAY'S APPOINTMENT

Reason for Appointment: _____

How long have you had this problem? _____

Previous treatment: _____

Comments: _____

If female, are you pregnant? YES NO

PATIENT MEDICAL HISTORY

Are you allergic to medications? NO YES, to what _____

EAR, NOSE AND THROAT SYSTEM REVIEW

CHECK ALL THAT APPLY

- EAR:** Pain Vertigo Ringing
 Hearing Loss Noise Exposure Wax Impaction
 Drainage History of Infection
- NOSE:** Bleeding Postnasal Drainage Obstruction
 Previous Injury Congestion Stuffiness
- THROAT:** Sore Throat/
Difficulty Swallowing Cough Hoarseness
- ALLERGY/SINUS:** Headaches Facial Pressure Asthma
 Sneezing Itchy/Watery Eyes Frequent Infections
- SLEEP PATTERNS:** Airway Obstruction Daytime Fatigue Snoring
- SKIN LESIONS/CANCER:** _____
- CONSTITUTIONAL:** Fever Weight Loss
- SKIN:** Rashes Hair Change Itching
- EYES:** Glaucoma Visual Changes Double Vision
- CARDIOVASCULAR:** Heart Attack Heart Diseases Chest Pain
 High Blood Pressure Irregular Heartbeat
- RESPIRATORY:** Pneumonia Emphysema Bronchitis
- GASTROINTESTINAL:** Ulcers/Colitis Nausea Diverticulitis
 Indigestion Diarrhea
- MUSCULOSKELETAL:** Rheumatoid Arthritis Neck Injury
- NEUROLOGICAL:** Dizziness Weakness/Numbness Migraines
 Fainting Seizures Strokes
- ENDOCRINE:** Thyroid Sweating Diabetes
- ALLERGIC/IMMUNOLOGIC:** Skin Rash/Infections Allergy Injections

Name: _____ D.O.B.: _____

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

CHECK ALL THAT APPLY

CHILDHOOD ILLNESS: __ Measles/Rubella __ Mumps __ Chicken Pox

MAJOR ILLNESSES/INJURIES: _____

IMMUNIZATIONS: __ Tetanus __ MMR __ DPT

SURGERIES: __ Tonsils/Adenoids Approximate Date: _____
 __ Thyroid Approximate Date: _____

OTHER HOSPITALIZATIONS:

Reasons/Dates: _____

FAMILY HISTORY: __ Allergies __ Asthma __ Thyroid
 __ Diabetes __ Anesthesia Problems __ Hearing Loss
 __ Head/Neck Cancer __ Bleeding Disorders

PRESENT MEDICATIONS: (LIST DOSAGE AND FREQUENCY)

_____ dose _____ times per day _____
_____ dose _____ times per day _____
_____ dose _____ times per day _____
_____ dose _____ times per day _____
_____ dose _____ times per day _____

SOCIAL HISTORY:

TOBACCO: __ None __ Packs per day __ Chewing ____ Years

ALCOHOL: __ None __ Rare __ Social ____ Amount

DRUG USE/HISTORY: __ Yes __ No

REVIEWED WITH PATIENT: _____

DOCTORS USE ONLY

DATA: __ X-Rays __ Bloodwork __ Cultures __ Audio

SPECIAL: _____

COMPLEXITY DATA:	Min	Low	Med	High
RISKS - COMPLICATIONS:	Min	Low	Med	High
MORTALITY:	Min	Low	Med	High
PRESENTING PROBLEM:	Min	Low	Med	High

DIAGNOSIS: _____

MANAGEMENT: _____

DISCUSSED: __ CT Scans __ RAST Testing __ Literature/Handouts provided

RETURN: __ Days __ Weeks __ PRN with instructions
