PATIENT INFORMATION

Patient Name_____ Birth Date_____

Last Name **First Name** **Middle (initial)**

Patient Employer_____ Patient Occupation _____

Reason For Your Visit Today_____

Doctor who referred you _____ Who is your regular doctor? _____

PAST OR PRESENT MEDICAL PROBLEMS (*Circle any problems you have or had*):

High Blood Pressure	Diabetes	Allergies	Rheumatic Fever	HIV/AIDS	Depression	Jaundice
Angina	Asthma	Ear Infections	Kidney Stones	Hepatitis (A B C)	Fibromyalgia	Head Injury
Heart Attack	Bronchitis	Hearing Loss	Kidney Failure	Arthritis	Chicken Pox	Goiter
Irregular Heart Rate	Emphysema	Meniere's Disease	Urinary Infection	Anemia	Blood Clots	TMJ
Other Heart Disease	Tuberculosis	Sinus Infections	Seizures	Stomach Ulcers	Excessive bleeding	Pneumonia
Bleeding Disorder	Cancer (*Type/when*):_____		Stroke	Tonsillitis	Women: Are you Pregnant …… No Yes	

Please list all other Illnesses: _____

SURGICAL HISTORY (*Please circle any surgeries you have had, and when*)

Ear Tubes	Tonsillectomy	Thyroid Surgery	Knee Replacement	Hysterectomy	Gall Bladder	Prostate Surgery
Ear Drum Repair	Septum Repair	Cardiac Bypass	Hip Replacement	Tubal Ligation	Appendectomy	Hernia
Mastoidectomy	Sinus Surgery	Cataracts	Cesarean Section	Skin Cancer		

Please List Other Operations (*please list type*): _____

_____

_____

_____

List All Current Medications (*including over-the-counter*)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are You Allergic To? *(Please Circle No or Yes)*

Penicillin…… No Yes
Sulfa…….. No Yes
"Mycin" …..…….. No Yes
Aspirin……... No Yes
Codeine……. No Yes
Tetanus…….. No Yes
Demerol……. No Yes
Other Medications. No Yes

List Other Medication Allergies:

_____
_____
_____

FAMILY HISTORY

Anyone else in the family with the same problems?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Number of Children_____
Do you use Tobacco? …… No Yes
Packs per day_____Years _____
Stopped Tobacco When?_____
Alcohol Usage ……..……. No Yes
Type/Quantity _____
Do you use Street Drugs …...…. No Yes
Ever had a blood transfusion? ….No Yes

***FOR CHILDREN* less than 12 years old**:
Birth Weight_____
Prenatal problems?_____
Immunizations up to date?_____
Number of people in home_____
Any second hand smoke?_____
Any house pets?_____
Grade Level_____Day Care?_____

EARS/NOSE/MOUTH/ THROAT

Hearing loss	❑ none	❑ right	❑ left	❑ both
Ringing in ears	❑ none	❑ right	❑ left	❑ both
Ear pain	❑ none	❑ right	❑ left	❑ both
Ear Drainage	❑ none	❑ right	❑ left	❑ both
Previous ear surgery:	❑ none	❑ right	❑ left	❑ both

Chronic sinus probs	❑ no	❑ yes_____
Nasal obstruction	❑ no	❑ yes_____
Nosebleeds	❑ no	❑ yes_____
Mouth sores	❑ no	❑ yes_____
Chronic sore tongue	❑ no	❑ yes_____
Sore throat	❑ no	❑ yes_____
Voice change	❑ no	❑ yes_____
Hoarseness	❑ no	❑ yes_____
Difficulty swallowing	❑ no	❑ yes_____
Painful swallowing	❑ no	❑ yes_____
Swelling in neck	❑ no	❑ yes_____

GENERAL

Good General health	❑ no	❑ yes_____
Easy Bleeding	❑ no	❑ yes_____
Easy Bruising	❑ no	❑ yes_____
Heart trouble	❑ no	❑ yes_____
Chronic cough	❑ no	❑ yes_____
Heartburn	❑ no	❑ yes_____
Frequent Headaches	❑ no	❑ yes_____
Thyroid disease	❑ no	❑ yes_____
Double vision	❑ no	❑ yes_____

ALLERGIC

Hay fever	❑ no	❑ yes_____
Food allergies	❑ no	❑ yes_____
Eye itchiness	❑ no	❑ yes_____
Nose itchiness	❑ no	❑ yes_____
Sneezing	❑ no	❑ yes_____