Associated Coastal ENT
Ear, Nose, Throat & Facial Plastic Surgery

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: _____
If female, are you pregnant? _____YES _____NO

PATIENT MEDICAL HISTORY

Are you allergic to medications? NO _____ YES _____, to what? _____
Height: _____ Weight: _____

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: ENT _____ Date _____
Other _____ Date _____
_____ Date _____
_____ Date _____

OTHER HOSPITALIZATIONS: Reasons/Dates _____

_____

OTHER MEDICAL NOT PREVIOUSLY SPECIFIED: _____

_____

FAMILY HISTORY: **Please check all that applies and which family member affected**

Allergies _____ Asthma _____
Thyroid _____ Head/Neck Cancer_____
Diabetes _____ Anesthesia Problems_____
Hearing Loss _____ Bleeding Disorders_____
Other _____ Other _____

PRESENT MEDICATIONS: **(LIST DOSAGE AND FREQUENCY) or we will copy your list**

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

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

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

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

SOCIAL HISTORY:

TOBACCO: __Never __Former __Packs per day __Chewing _____ Years

ALCOHOL: __None __Rare __Social _____Amount per week

DRUG USE/HISTORY: __Yes __No

REVIEWED WITH PATIENT: _____