

Family ENT New Patient History

NAME: _____ Date: _____ Referred by: _____

REASON FOR VISIT TODAY: _____

Medications: Please list all medications including over-the-counter and herbal medications: None: _____

Medication and dose	Problem being treated

Medication allergies: Yes _____ No _____

Name of medication causing reaction	Type of reaction (hives, nasal congestion, nausea, etc.)

Allergy History

Do you have any environmental allergies to pollen, dust, food, latex, etc.? Yes _____ No _____

If yes, list allergens and type of reaction: _____

Have you ever had an allergy skin test or blood test? Yes _____ No _____

If yes, date of test and results: _____

Have you ever taken allergy shots? Yes _____ No _____ When? _____ Were they helpful? Yes _____

No _____

Past Medical and Surgical History

Please circle any condition or illness you have had:

Asthma	COPD	Heart Disease	High Blood Pressure
Diabetes	Kidney Disease	Liver Disease	Cancer
Thyroid disorder	Gastric reflux	Bleeding problems	Sleep apnea
Stroke/TIA	Tuberculosis	Seizures	Psychiatric

Any problems not listed above? _____

Any surgeries? Yes _____ No _____ Please list all surgeries and approx. dates: _____

Any problems with anesthesia? Yes _____ No _____ If yes,

describe: _____

Prior hospitalizations? List reason and dates: _____

Height and Weight

Height: _____

Weight: _____

Diagnostic tests and immunizations

Mammogram: Date of last exam: _____

Pneumonia vaccine - Date of vaccination: _____

CT or MRI of head or sinuses - date and facility where it was done: _____

Family History

Do you have any family members with any of the following? Indicate family relationship and describe:

Serious illness or cancer? _____

Hearing loss? _____

Adverse reaction to anesthesia? _____

Bleeding or clotting problem? _____

Social History

What is your occupation? _____

Are you retired? Yes _____ No _____

Have you ever used tobacco? Yes _____ No _____ Cigarettes per day: _____ From (year): _____ To (year): _____

Other type of tobacco? Yes _____ No _____ From (year): _____ To (year): _____

Are you exposed to second hand smoke? Yes _____ No _____ Where? _____ home _____ work
_____ other

Review of Systems

Please circle any symptoms that you are having today:

General	Fever	Fatigue	Sweating	Weight change
Eyes	Loss of vision	Blurred vision	Tearing	Pain
Ears	Ringing	Discharge	Hearing loss	Pain Dizziness
Nose	Congestion Sneezing	Obstruction Bleeding	Pain Loss of smell	Runny nose Post-nasal drainage
Throat	Pain Difficulty swallowing	Snoring/Sleep apnea	Loss of taste	Growth
Neck	Mass or lump	Pain		
Cardio-vascular	Chest pain Palpitations	Irregular heart beat		
Pulmonary	Shortness of breath Productive Cough	Wheezing	Dry cough	
Gastrointestinal	Heartburn Diarrhea/constipation	Nausea/vomiting	Pain	
Muscles/Bones	Joint pain	Muscle aches	Arthritis	
Neurological	Headaches Paralysis	Tingling	Numbness	

Psychiatric	Depression Anxiety	Memory loss	Confusion
Endocrine	Hyper-active cold intolerance	Fatigue	Excessive thirst Heat or
Renal	Trouble urinating	Excessive urination	

Please list anything else you think is important to your visit today: _____
