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:____

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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 Obstruction Pain Runny nose Post-nasal drainage Sneezing Bleeding Loss of smell
Throat	Pain Snoring/Sleep apnea Loss of taste Growth Difficulty swallowing
Neck	Mass or lump Pain
Cardio-vascular	Chest pain Irregular heart beat Palpitations
Pulmonary	Shortness of breath Wheezing Dry cough Productive Cough
Gastrointestinal	Heartburn Nausea/vomiting Pain Diarrhea/constipation
Muscles/Bones	Joint pain Muscle aches Arthritis
Neurological	Headaches Tingling Numbness Paralysis

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

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