



Associates in Ear, Nose, Throat and Facial Plastic Surgery, P.A.

Last Name _____ First Name _____ Initial _____ Age _____

Today's Date ___/___/___ Birth Date ___/___/___ Ref. Physician _____ Office W C M T E W i

Please give us your medical history by completing the following:

Chief Complaint (what are your current symptoms?): _____

Past Medical History:

List your current medications including over-the-counter drugs such as aspirin, Tylenol, Motrin, nasal sprays, etc.

Medication	Dose	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any medication allergies:

Drug	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Have you had or do you currently have any of the following medical conditions?
If so, please include the year it first occurred.

Yes	No	Year		Yes	No	Year	
_____	_____	_____	High blood pressure	_____	_____	_____	Irregular Heart beat
_____	_____	_____	Coronary artery disease	_____	_____	_____	Myocardial infarction
_____	_____	_____	Asthma	_____	_____	_____	Emphysema
_____	_____	_____	Tuberculosis	_____	_____	_____	Pneumonia
_____	_____	_____	Colitis	_____	_____	_____	Stomach or duodenal ulcer
_____	_____	_____	Esophageal reflux	_____	_____	_____	Hiatal hernia
_____	_____	_____	Cirrhosis	_____	_____	_____	Hepatitis
_____	_____	_____	AIDS	_____	_____	_____	Bladder problems
_____	_____	_____	Kidney problems	_____	_____	_____	Enlarged prostate
_____	_____	_____	Bone disease	_____	_____	_____	Arthritis
_____	_____	_____	Skin cancer	_____	_____	_____	Anxiety
_____	_____	_____	Depression	_____	_____	_____	Thyroid problems
_____	_____	_____	Diabetes	_____	_____	_____	Infectious mononucleosis
_____	_____	_____	Blood disorder	_____	_____	_____	Anemia
_____	_____	_____	Sickle cell anemia	_____	_____	_____	Keloids
_____	_____	_____	Cancer	_____	_____	_____	Lyme disease
_____	_____	_____	Epilepsy	_____	_____	_____	Migraine headaches
_____	_____	_____	Glaucoma	_____	_____	_____	Positive HIV test
_____	_____	_____	Cataracts	_____	_____	_____	High cholesterol
_____	_____	_____	Multiple Sclerosis	_____	_____	_____	_____

Past Medical History Cont.

Have you had any of the following operations? Please tell us the year it was performed.

Operation	Year	Operation	Year	Operation	Year
Tonsils or adenoids	_____	Hernia repair	_____	Gall bladder	_____
Appendix	_____	Hysterectomy	_____	Wisdom teeth	_____
D&C	_____	Coronary bypass	_____	Ear surgery	_____
Sinus surgery	_____	Cataracts	_____	Nasal surgery	_____
_____	_____	_____	_____	_____	_____

Family History

Do any of the following diseases tend to run in your family? (Circle any that apply)

Heart Disease Cancer Tuberculosis Hypertension Diabetes Autoimmune Diseases
 Allergies Bleeding disorder Other _____

	If Living		If Deceased	
	<u>Age</u>	<u>Health</u>	<u>Age at Death</u>	<u>Cause of Death</u>
Biological Father	_____	_____	_____	_____
Biological Mother	_____	_____	_____	_____
Brothers/Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

Social History

Tobacco:

Have you ever smoked? Y N #years you smoked _____ #packs per day _____
 Do you currently smoke? Y N When did you stop smoking? _____

Alcohol:

Do you drink alcohol? Y N Number of years _____
 How much do you drink? _____ Daily/weekly (circle one)

Drug Abuse:

Is there any history of drug abuse?
 If so, what _____

Caffeine: (coffee, tea and caffeinated soft drinks)

Estimate daily consumption (number of cups or glasses): Coffee _____ Tea _____ Soft Drinks _____

Review of Systems

Please check any ongoing symptom that you have not already told us about:

- | | | |
|--|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Abdominal Pain or Cramps | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Regurgitation | <input type="checkbox"/> Belching | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Frequency of Urination | <input type="checkbox"/> Burning on Urination | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Muscle or Joint Pain | <input type="checkbox"/> Rash | <input type="checkbox"/> Heat Intolerance |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Rapid Weight Gain |
| <input type="checkbox"/> Rapid Weight Loss | <input type="checkbox"/> Difficulty Speaking | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Nasal Discharge |
| <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Repetitive Sneezing | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Draining Ears | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Food Allergy |
| <input type="checkbox"/> Inhalant Allergy | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Excessive Tearing | <input type="checkbox"/> Generalized Weakness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Irregular Menstrual Periods | <input type="checkbox"/> Heavy Menstrual Periods | <input type="checkbox"/> _____ |

Work History (Please tell us the type of work you do, where you have been employed and the years you worked there)

Are you pregnant? Y N If so, how many weeks _____

Are you currently breast-feeding? Y N

Do you require premedication with antibiotics before dental or surgical procedure? Y N

Patient or Guardian signature _____

Reviewed: _____/_____/_____/_____/_____/_____/_____/_____