Name:

Date:

Referring Provider:

What are your concerns for today's visit? _____

LIST ANY ***ALLERGIES TO MEDICATIONS:***

PAST MEDICAL HISTORY:

1) Please check the "YES" or "NO" box to indicate whether you have any of the following illnesses; for "YES" answers, please explain

	Yes	No	Explain		Yes	No	Explain
Diabetes	☐	☐		Stomach or Intestinal Problems	☐	☐	
Hypertension (high blood pressure)	☐	☐		Allergy problems/therapy	☐	☐	
Thyroid Problems	☐	☐		Kidney Problems	☐	☐	
Heart Disease/Cholesterol	☐	☐		Neurological Problems	☐	☐	
Respiratory Problems	☐	☐		Hepatitis	☐	☐	
Other Medical Diagnosis	☐	☐		Immune Deficiency	☐	☐	
Facial Fracture /Trauma	☐	☐					

Exposure to Toxic Chemicals	Y	N	Trauma to Head	Y	N
Loud Blasts or Noise Exposure	Y	N	Family History of Hearing Loss	Y	N

2) Please list any operations (and Dates) you have ever had (including tonsils & adenoids):

Type of surgery	Date of surgery	Hospital or place of surgery

3) Please list any current medications (and amounts, times per day):
(including aspirin, antacids, vitamins, hormone replacements, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds)

SOCIAL HISTORY

	Yes	No	Please list details below:
Do you smoke?	☐	☐	How much? _____ How many years? _____
If no, did you smoke previously?	☐	☐	
Do you drink alcohol?	☐	☐	How much? _____ What type(s) _____
Use of recreational drugs?	☐	☐	How often? _____ What type(s) _____

FAMILY HISTORY

Please check the "YES" or "NO" box to indicate whether any relatives have any of the following illnesses:
If yes, please indicate which relative(s) have the problem.

	Yes	No	
Hearing or balance problems	☐	☐	
Allergy	☐	☐	
Diabetes	☐	☐	
Cancer	☐	☐	
Bleeding Disorder	☐	☐	
Anesthesia problems	☐	☐	
Heart problems	☐	☐	
Other	☐	☐	

REVIEWED BY:

Name:
Chart:
Date:

Please provide the following medical information to the best of your ability:

Review of Systems:

1) Please check the "YES" or "NO" box to indicate whether you presently have any of the following symptoms:
2) For any "YES" response, please check the "Current" box if this symptom relates to the reason for your visit today:

		Yes	No	Current		Yes	No	Current
ALLERGY	Sneezing	☐	☐	☐	Post nasal drip	☐	☐	☐
	Seasonal allergy	☐	☐	☐				
ENT	Ear pain or itch	☐	☐	☐	Ear drainage	☐	☐	☐
	Hearing loss	☐	☐	☐	Ear noises	☐	☐	☐
	Recurrent ear infections	☐	☐	☐	Swelling neck/face	☐	☐	☐
	Dizziness, Vertigo	☐	☐	☐	Lightheadedness	☐	☐	☐
	Nasal congestion	☐	☐	☐	Sinus pressure/pain	☐	☐	☐
	Nose bleeds	☐	☐	☐	Sense of smell problem	☐	☐	☐
	Recurrent sinus infections	☐	☐	☐	Discolored nasal discharge	☐	☐	☐
	Problem snoring	☐	☐	☐	Snoring with pauses	☐	☐	☐
	Hoarseness	☐	☐	☐	Throat pain	☐	☐	☐
	Throat clearing	☐	☐	☐	Throat dryness/itching	☐	☐	☐
RESPIRATORY	Cough	☐	☐	☐	Coughing blood	☐	☐	☐
	Wheezing	☐	☐	☐	Shortness of breath	☐	☐	☐
	Noisy breathing	☐	☐	☐				
EYES	Eye pain	☐	☐	☐	Watery or itchy eyes	☐	☐	☐
GI	Difficulty swallowing	☐	☐	☐	Heartburn, reflux	☐	☐	☐
NEURO	Headache	☐	☐	☐	Passing out	☐	☐	☐
GENERAL	Chills	☐	☐	☐	Weight loss/pain	☐	☐	☐
	Fatigue	☐	☐	☐	Daytime sleepiness	☐	☐	☐
ENDO	Feel warmer than others	☐	☐	☐	Feel cooler than others	☐	☐	☐
HEME/LYM	Swollen glands	☐	☐	☐	Sweating at night	☐	☐	☐
	Bleeding problems	☐	☐	☐	Easy bruising	☐	☐	☐
CARDIAC	Chest pain	☐	☐	☐	Palpitations	☐	☐	☐
MSK	Joint aches	☐	☐	☐	Muscle aches	☐	☐	☐
SKIN	Rash	☐	☐	☐	Hives	☐	☐	☐
	Itching	☐	☐	☐	Skin/hair changes	☐	☐	☐
	Strawberry birth marks							
PYSCH	Depression	☐	☐	☐	Anxiety or panic	☐	☐	☐

REVIEWED BY: