FAMILY ENT EAR, NOSE AND THROAT CLINIC, P.C.

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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: _____ 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 secondhand 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 Dizziness	Discharge	Hearing Loss	Pain
Nose	Congestion Postnasal Drainage	Obstruction Sneezing	Pain Bleeding	Runny Nose Loss of Smell
Throat	Pain Difficulty Swallowing	Snoring/Sleep Apnea	Loss of Taste	Growth
Neck	Mass or Lump	Pain		
Cardiovascular	Chest Pain	Irregular Heartbeat	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	Hyperactivity	Fatigue	Excessive Thirst	Heat or Cold Intolerance
Renal	Trouble Urinating	Excessive Urination		

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

_____