

# Ear, Nose & Throat Associates

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

## Medications:

See Attached

No Medications Taken

Can't remember Medications

1.) \_\_\_\_\_ Dose: \_\_\_\_\_

2.) \_\_\_\_\_ Dose: \_\_\_\_\_

3.) \_\_\_\_\_ Dose: \_\_\_\_\_

4.) \_\_\_\_\_ Dose: \_\_\_\_\_

5.) \_\_\_\_\_ Dose: \_\_\_\_\_

6.) \_\_\_\_\_ Dose: \_\_\_\_\_

Medication Allergies:

1.) \_\_\_\_\_

2.) \_\_\_\_\_

No Known Drug Allergies

## Medical Conditions:

Aids  Cancer and what type: \_\_\_\_\_

Anemia \_\_\_\_\_

Asthma \_\_\_\_\_

Bleeding  Other: \_\_\_\_\_

Bronchitis \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart Disease \_\_\_\_\_

Hepatitis \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Kidney Disease \_\_\_\_\_

Pregnant \_\_\_\_\_

Psychiatric Disorder \_\_\_\_\_

Seizures \_\_\_\_\_

Stroke \_\_\_\_\_

## Past Surgeries:

1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

4.) \_\_\_\_\_

Anesthesia Problem: \_\_\_\_\_

**No Changes Please Sign:**

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## Social History:

Tobacco use:

Never Smoked

1/2 Pack Daily Years: \_\_\_\_\_

1 Pack Daily Years: \_\_\_\_\_

2 Packs Daily Years: \_\_\_\_\_

Quit Smoking – Date: \_\_\_\_\_

Chew Tobacco

Quit Chewing – Date: \_\_\_\_\_

Alcohol use:

Non-Drinker

1 Drink Daily

2 Drinks Daily

3 or more Drinks Daily

Occasional

Occupation: \_\_\_\_\_

\_\_\_\_\_

Child:

Household smoking

Daycare or Pre-K

## Family Medical History:

Disease	Family Member	Location (if cancer)
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1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

## Are you having a problem with any of the following ( Please explain if YES )

No	Yes
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Fever: \_\_\_\_\_

Weight loss \_\_\_\_\_

Skin \_\_\_\_\_

Eyes \_\_\_\_\_

Neurological (nerves) \_\_\_\_\_

Heart\ Circulation \_\_\_\_\_

Lungs\Breathing \_\_\_\_\_

Digestive\Abdominal \_\_\_\_\_

Bleeding\Swelling \_\_\_\_\_

Hormonal \_\_\_\_\_

Muscular\Joint \_\_\_\_\_

Psychiatric\ Depression \_\_\_\_\_

Urinary \_\_\_\_\_

Seasonal Allergies\Immune \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

List any recent testing (labs, Radiology testing ect.)

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