Patient Medical History

Patient Name: _____ Date of Birth: _____

Referring/Primary Care Provider: _____

Pharmacy Name & Location: _____

Reason for today's visit: _____

Past Medical History: check ALL that apply, including past and current diagnoses

☐ High Blood Pressure	☐ Heart Attack (MI) Date:	☐ Stroke
☐ Atrial Fibrillation	☐ Coronary Artery Disease	☐ Kidney Failure
☐ Asthma	☐ Bleeding Disorder	☐ DVT
☐ Sleep Apnea	☐ COPD/Chronic Bronchitis	☐ HIV
☐ Acid Reflux	☐ Diabetes Most recent HbA1C:	☐ Hepatitis B or C
Cancer (type & location): ☐ Chemotherapy ☐ Radiation Treatment	Other Medical Problems not Listed Above:	

Past Surgeries Pertaining to ENT: check ALL that apply, include the years the surgery was performed

	Year		Year		Year
☐ Ear Tubes		☐ Tympanoplasty		☐ Mastoidectomy	
☐ Septoplasty		☐ Rhinoplasty		☐ Sinus Surgery	
☐ Tonsillectomy		☐ Adenoidectomy		☐ Thyroidectomy	
☐ Cardiac Stents		☐ Cardiac Bypass		☐ Gastric bypass or banding	
☐ Skin Cancer		☐ Kidney Transplant			
Other Surgery not Listed Above:					

Family History: check ALL that apply

	Family Member		Family Member
☐ Asthma		☐ Thyroid Cancer	
☐ Bleeding Disorder, Type:		☐ Other Cancer Type:	
☐ Hearing Loss:		☐ Heart Attack	
☐ Problems with Anesthesia		☐ Stroke before age 60	
Additional Family History:			

Social History:

Do you currently use	**Are you (please circle one)**
Tobacco If so how much per day?	Employed Yes No Workplace/Employer:
Alcohol If so how much per day?	Married Yes No

Review of Systems

Patient Name: _____

Height: _____ **Weight:** _____

Please list all current medications, including over-the-counter

Medications _____

_____

_____

Medication Allergies (please specify if mild, medium or severe)_____

_____

_____

Please check yes or no if you CURRENTLY have the following symptoms

ENT	Yes	No		Yes	No
Hearing Loss			Facial Pain		
Ringing in the ears			Loss of smell		
Room spinning dizziness			Postnasal drip		
Ear pain			Snoring		
Ear discharge			Difficulty swallowing		
Runny nose			Pain with swallowing		
Problem with nasal breathing			Hoarseness		
Itchy nose			Nosebleeds		
Lump in neck					

Neurologic	Yes	No	Cardiovascular	Yes	No
Headaches			Chest pain		
Numbness			Irregular Heartbeat		
Weakness			Shortness of breath		
Blurred Vision					
Double Vision					

Musculoskeletal	Yes	No	Skin	Yes	No
Joint Pain			Dry Skin		
Joint Swelling			Concerning Mole		
Limited Mobility			Itchy Skin		

General	Yes	No	Genitourinary	Yes	No
Fever			Frequent Urination		
Recent Weight Loss			Nocturnal Urination		
Night Sweats			Painful Urination		
Fatigue					