

Pt. Name: _____

Address: _____

City State Zip

MRN: _____

DOB: _____

SSN: XXX-XX-____ SEX: _____

DOS: _____

Age: _____ Name of Referring Physician: _____

Address of Referring Physician: _____

Fax Number of Referring Physician: _____

Family Physician (if different): _____

What symptoms led to your visit today? _____

Do you have, or have you ever had any of the following (please mark if **YES**):

- | | | | |
|---|--|--|---|
| <input type="radio"/> High blood pressure | <input type="radio"/> Asthma | <input type="radio"/> Diabetes | <input type="radio"/> Memory lapses |
| <input type="radio"/> Heart trouble | <input type="radio"/> Shortness of breath | <input type="radio"/> Thyroid problems | <input type="radio"/> Epilepsy |
| <input type="radio"/> Chest pain | <input type="radio"/> Bronchitis | <input type="radio"/> Urinary problems | <input type="radio"/> IV drug use |
| <input type="radio"/> Heart burn | <input type="radio"/> Pneumonia | <input type="radio"/> Prostate problems | <input type="radio"/> Drug addiction |
| <input type="radio"/> Stomach ulcer | <input type="radio"/> Tuberculosis | <input type="radio"/> Kidney disease | <input type="radio"/> Alcoholism |
| <input type="radio"/> Duodenal ulcer | <input type="radio"/> Chronic lung disease | <input type="radio"/> Blood disorder | <input type="radio"/> AIDS/HIV |
| <input type="radio"/> Intestinal bleeding | <input type="radio"/> Cancer | <input type="radio"/> Blood transfusion | <input type="radio"/> Venereal disease |
| <input type="radio"/> Bowel disorder | <input type="radio"/> Eye disease | <input type="radio"/> Anemia | <input type="radio"/> Rheumatic fever |
| <input type="radio"/> Liver problems | <input type="radio"/> Migraine headache | <input type="radio"/> Prolonged bleeding | <input type="radio"/> Psychiatric treatment |
| <input type="radio"/> Hepatitis or jaundice | <input type="radio"/> Arthritis | <input type="radio"/> Stroke | <input type="radio"/> Illegal drug use |

Hearing problems? Which ear? Right Left Both How long? _____

Was your hearing loss Gradual Sudden Varying

Hear noises in your head? Which ear: Right Left Both When did it start? _____ How often? _____

Which describes the noise? High pitch ringing Crickets Roaring Pulsating

Ever been exposed to noise for long periods of time?

Ever been tested for allergies?

Ever been on allergy shots?

Are you currently on allergy shots?

MEDICAL PROBLEMS (list other current or previous medical conditions): _____

SURGERY (list previous operations and dates):

Tonsils _____ Appendix _____ C-section _____ Hysterectomy _____

Other _____

PLEASE COMPLETE QUESTIONS ON THE BACK SIDE OF THIS SHEET

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Address: _____

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HOSPITALIZATIONS (list reasons and dates you have been a patient in the hospital, OTHER THAN FOR SURGERY):

MEDICATIONS (list any medications you are currently taking):

Do you have any DRUG REACTIONS or DRUG ALLERGIES: No Yes _____
If yes, what type of reactions do you have? _____

Do you have any risk factors for AIDS/HIV? No Yes
(e.g., blood transfusion, occupations, IV drugs, sexual contact)

FAMILY HISTORY

Father: Alive Dead Medical problems: _____
Cause of death: _____

Mother: Alive Dead Medical problems: _____
Cause of death: _____

Siblings: Alive Dead Medical problems: _____
Cause of death: _____

Other medical problems in family: Cancer Diabetes Heart attack Stroke Hearing problems
 Allergy (hay fever, eczema, asthma) Other (list) _____

SOCIAL HISTORY

Occupation: _____ Marital status: S M D W

Cigarettes: Never smoked Currently smoking Quit: How many years ago? _____
If you ever smoked? How many packs per day? _____ How many years have you, or did you smoke? _____

Other tobacco: Never used Pipe Cigar Dip snuff Chew tobacco Currently using
 Quit: How many years ago? _____ How much/day: _____ How many years: _____

Are you exposed to smoke at home or work?

Alcohol: Do not use Never have used Quit: How many years ago? _____

Do you use: Beer Wine Liquor Amount: _____ per: Week Month

What is your height: _____ Weight: _____

Completed by: _____ Date: _____

FOR OFFICE USE ONLY

BP _____ P _____ R _____ WT _____ (lbs)

I have read and reviewed these results with the patient and/or responsible party.

Physician's Signature: _____ Date: _____

OTOLARYNGOLOGY