E.N.T. SURGICAL ASSOCIATES, P.C.

Name ______________________ Date ______________

Birthdate ______________________ Birthplace ______________

Occupation ______________________ Referring Doctor ______________

YOUR MEDICAL HISTORY: (Please circle yes or no)

Condition			Condition			Condition		
Acid Reflux	No	Yes	Epilepsy / Seizures	No	Yes	Neuritis / Neuralgia	No	Yes
Anemia	No	Yes	Fainting Spells	No	Yes	Nervous Breakdown	No	Yes
Anxiety / Depression	No	Yes	Frequent Colds / Sore Throats	No	Yes	Paralysis	No	Yes
Arthritis / Bone, Joint Disease	No	Yes	Glaucoma	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Gonorrhea / Syphilis	No	Yes	Sleep Apnea / Snoring	No	Yes
Bleeding Disorders	No	Yes	Heart Disease	No	Yes	Stomach Ulcers	No	Yes
Cancer	No	Yes	Herpes / Cold Sores	No	Yes	Stroke	No	Yes
Chronic Bronchitis	No	Yes	High Cholesterol	No	Yes	Tuberculosis	No	Yes
Circulation Problems	No	Yes	High / Low Blood Pressure	No	Yes	Have you been exposed in the past to any loud or unusual noises?	No	Yes
Diabetes	No	Yes	Hives / Eczema	No	Yes			
Dizziness	No	Yes	Influenza	No	Yes	Are you exposed to chemicals or have you been in the past?	No	Yes
Drug / Chemical Poisoning	No	Yes	Jaundice / Hepatitis	No	Yes			
Emphysema / COPD	No	Yes	Kidney Disease	No	Yes	Have you been in the military service?	No	Yes
Enlarged Glands	No	Yes	Meningitis	No	Yes			
Enlarged Prostate	No	Yes	Migraine Headaches	No	Yes	Have you ever been involved in a malpractice suit?	No	Yes
Enlarged Thyroid / Goiter	No	Yes	Multiple Sclerosis	No	Yes			

REVIEW OF SYSTEMS: Please check box if you are experiencing any of the following symptoms:

- ☐ Bleeding gums, bruise easily, swollen lymph nodes.
- ☐ Blurred or loss of vision, double vision, dry eyes, eye pain.
- ☐ Chest pain, rapid heartbeat, lightheadedness.
- ☐ Cold or heat intolerance, excessive thirst or urination, irregular menstruation.
- ☐ Fever, chills, night sweats, weight loss.
- ☐ Frequent colds, ear or sinus infections, sneezing, itchy runny nose, sore throat.
- ☐ Heartburn, difficulty swallowing, stomach/abdominal pain, vomiting, blood in stool, dark tarry stools.
- ☐ Joint or muscle pain.
- ☐ Numbness or tingling, difficulties with balance or coordination, frequent headaches.
- ☐ Shortness of breath, difficulty breathing, cough.
- ☐ Skin lesions, non-healing sores, rash, itching.

WOMEN:

Last menstrual cycle: ______________

# of pregnancies: ______________

Natural ________ C-Section ________

SURGERY: (List all operations)

____

____

____

____

List medications (including aspirin, hormones, diet pills, etc.): ______

____

____

____

____

____

HABITS:

Alcoholic Beverages: ☐ Never ☐ Barely ☐ Moderate ☐ Daily

Tobacco: Cigarettes ____ packs/day for _____ years

Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Snuff ☐

Use of Recreational Drugs: ☐ No ☐ Yes

List allergies (including medications, foods, tape, etc.): ________

____

____

____

FAMILY HISTORY: Has any blood relative had any of the following diseases? (Please circle answer)

Disease			Who?	Disease			Who?
Bleeding Problems	No	Yes		Heart Trouble	No	Yes	
Cancer	No	Yes		High Blood Pressure	No	Yes	
Diabetes	No	Yes		Stroke	No	Yes	
Hearing Loss	No	Yes					

Any medical problems not noted? ______________________

Reason for seeing doctor: ______________________

Patient Signature: ______________________