



PATIENT HISTORY

Patient Name: _____ **DOB:** _____ **Date:** _____

Primary Care Doctor:

Referring Doctor:

Reason For Your Visit Today:

Surgery: (include head/brain, neck or another major surgery's give year/location/surgeon if you remember) _____

Medical History (Any major illness, hospitalization, current diagnoses see below):

Social History:

Smoke? () Yes () No

Current Smoker: How many Packs Per Day: _____

If Past Smoker: When did you quit Smoking: _____

Do you Smoke Vapes: () Yes () No

Ear, Nose & Throat

ASSOCIATES, MD, PA

Do you use smokeless tobacco: Yes No If so: Dip Chew Nicotine Gum/Patches

Drinking: Yes No How many alcoholic drinks per day: _____

Caffeine: Yes No How many cups per day: _____

Illicit substance: Yes No, If So what Substance: _____

ENT Disease History, Check any items below that may apply.					
<input type="checkbox"/> None	<input type="checkbox"/> Head Cancer	<input type="checkbox"/> Neck Cancer	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Sinus Cancer	<input type="checkbox"/> Nasal Cavity Cancer
<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> Basal Cell	<input type="checkbox"/> Squamous Cell	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Other Skin Cancer	<input type="checkbox"/> Acoustic Neuroma
<input type="checkbox"/> Cholesteatoma	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Mastoiditis	<input type="checkbox"/> Otitis Externa (Swimmer Ear)	<input type="checkbox"/> Otitis Media (Middle Ear Infections)	<input type="checkbox"/> Otosclerosis
<input type="checkbox"/> Tinnitus (Ringing or Other Noise of the ear)	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Facial Fracture	<input type="checkbox"/> Nasal Fracture	<input type="checkbox"/> Deviated Septum	<input type="checkbox"/> Septal Perforation
<input type="checkbox"/> Epistaxis (Nose Bleeds)	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss Of Taste	<input type="checkbox"/> Nasal Polyps	<input type="checkbox"/> Nasal Obstructions	<input type="checkbox"/> Allergic Rhinitis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Sinusitis	Vocal Cord Nodules	Vocal Cord Polyps	Vocal Cord Paralysis	Papilloma
<input type="checkbox"/> Hyperparathyroidism	<input type="checkbox"/> Neck Mass	<input type="checkbox"/> Parotid Tumor	<input type="checkbox"/> Sialadenitis (Infected or Inflamed Salivary Gland)	<input type="checkbox"/> Sialolithiasis (Stone of the Salivary Gland)	<input type="checkbox"/> Thyroglossal Duct Cyst
<input type="checkbox"/> Thyroid Nodules	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Oral Ulcers	<input type="checkbox"/> Brachial Cleft Cyst	<input type="checkbox"/> Tracheal Stenosis	<input type="checkbox"/> Subglottic Stenosis

Family Medical History: List any family history of stroke, seizure, nerve, muscle, memory, tremors, Parkinson's d/s, & migraines. Your Mother, Father and Grandparents current illnesses or cause and year/age of their death:

Mother: _____

Father: _____

Ear, Nose & Throat

ASSOCIATES, MD, PA

Sister: _____

Brother: _____

Grandparents: _____

Review of Symptoms: Check any items below that may apply.

<input type="checkbox"/> Bleeding	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Dysphonia	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Otagia	<input type="checkbox"/> Otorrhea	<input type="checkbox"/> Neck Mass	<input type="checkbox"/> Increased Infection	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Exercise Intolerance
<input type="checkbox"/> Fever	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heart Burn	<input type="checkbox"/> Melena	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Bruising	<input type="checkbox"/> Clots	<input type="checkbox"/> Increased Bleeding	<input type="checkbox"/> New Lesions	<input type="checkbox"/> Rash	<input type="checkbox"/> Musculoskeletal Pain
<input type="checkbox"/> Headaches	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Allergy to Adhesive	<input type="checkbox"/> Allergy to Latex	<input type="checkbox"/> Allergy to shellfish/Iodine	<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Cardiac Defibrillator	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Spinal Hardware	<input type="checkbox"/> Mechanical Valve	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pregnant or Planning	<input type="checkbox"/> Premedication prior to procedure	<input type="checkbox"/> Radioactive Iodine Treatment
<input type="checkbox"/> Recent Chemo	<input type="checkbox"/> Under Pain Management	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV	<input type="checkbox"/> XRT (Radiation Therapy)	<input type="checkbox"/> Other _____

All other Systems are negative

 Patient / Responsible Party Signature: _____ Date: _____

 Patient's Name
 (Printed): _____