

Patient Intake

Patient Name: _____ Date: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Family Doctor: _____ Referring Doctor: _____

Why are you here today?: _____

Have you had any medicine or treatment for it? Yes NoPlease List: _____
_____**ENT REVIEW OF SYMPTOMS****Check** any of the following symptoms that pertain to you:**EARS**

Right Left

- | | | | |
|--|--------------------------|--------------------------|---|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Dizziness (Spinning Sensation) |
| <input type="checkbox"/> Noise in Ears | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Off-Balance |
| <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Loud Noise Exposure (<input type="checkbox"/> Guns) (<input type="checkbox"/> Job) |
| <input type="checkbox"/> Earache | <input type="checkbox"/> | <input type="checkbox"/> | |

NOSE

- Congestion or Stuffiness
- Runny Nose
- Postnasal Drip
- Nosebleeds
- Broken Nose
- Sinus Infections
- Breathing Obstruction
- Abnormality of Smell

HEADACHE

- Where is it located? _____
- Constant
- Periodic
- Throbbing
- Pressure
- Nausea
- Sensitive to Light
- Eye Symptoms

THROAT

- Sore Throat
- Difficulty Swallowing
- Hoarseness
- Cough
- Mouth Ulcers
- Heartburn

FACE AND NECK

- Lump in Neck
- Non-healing Sore
- Change in Mole
- Scar
- Pain

Continued on the next page.

REVIEW OF SYMPTOMS

Are you currently having any problems with your:

Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lungs, Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness/Tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Digestion, Stomach Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint Aches/Pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowel Movements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression, Anxiety, etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appetite or Weight Change	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

ALLERGIES (Include medication allergies):

CURRENT MEDICATIONS YOU ARE TAKING:

SURGICAL HISTORY (Please list):

ARE YOU PREGNANT? Yes No

LATEX ALLERGY? Yes No

Past Medical History

Height: _____ Weight: _____ Age: _____

Check if you have or have had any of the following conditions:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Prostate Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Cataracts	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Seizures
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve	<input type="checkbox"/> Tuberculosis

Other Illnesses: _____

Any problems with blood clotting? Yes No

Family history of blood clotting problems? Yes No

Family History – Please Check All That Apply

<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer
<input type="checkbox"/> TB	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Kidney Disease		

Social History – Please Check All That Apply

Tobacco Use: Yes No Usage: < 1 pack/day 1 pack/day > 1 pack/day
Alcohol Consumption: Yes No Daily: 1-2 drinks/week 1-2 drinks/month 1-2 drinks/year
History of Substance Abuse: Yes No If yes, specify: _____
Recreational Drugs: Yes No If yes, specify: _____

I certify that the above information is true and correct.

Patient/Guardian Signature: _____

Reviewed by: _____ M.D. Date: _____