Patient Medical Information

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Date _____

Who may we thank for referring you?

Welcome To Our Practice!

_____

Name _____ Family Doctor _____

Current Problem _____

_____

How Long? _____

Previous medications for this problem _____

Previous Surgery for this problem _____

Ht: _____

Wt: _____

EAR / NOSE / THROAT — REVIEW OF SYMPTOMS:

YES	NO		YES	NO	
☐	☐	Sore throat	☐	☐	Ear ache
☐	☐	Difficulty Swallowing	☐	☐	Ear drainage
☐	☐	Painful swallowing	☐	☐	Ringing in ear
☐	☐	Hoarseness	☐	☐	Hearing loss
☐	☐	Headaches	☐	☐	Vertigo (dizziness)
		Location: _____	☐	☐	Wax impaction
		Frequency: _____	☐	☐	Ear pressure
☐	☐	Post nasal drip	☐	☐	Chronic caugh
☐	☐	Nasal obstruction	☐	☐	Productive caugh
☐	☐	Nasal stuffiness			Sputum: _____
☐	☐	Facial pressure			Color: _____
☐	☐	Bloody nose			Blood: _____

Medical History:

ALLERGIES to medication: ☐ Penicillin ☐ Novocaine/xylocaine ☐ Other _____

_____

MEDICATIONS Please list with dosage and frequency:

☐ Aspirin _____ ☐ Ibuprofen _____ ☐ Coumadin: _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

SERIOUS ILLNESSES:

YES	NO		YES	NO	
☐	☐	Glaucoma	☐	☐	Thyroid disease
☐	☐	Heart disease/attack	☐	☐	Ulcers/Indigestion
☐	☐	High blood pressure	☐	☐	Jaundice
☐	☐	Angina	☐	☐	Gall bladder disease
☐	☐	Irregular heartbeat	☐	☐	Colitis/Diverticulitis
☐	☐	Emphysema/Bronchitis	☐	☐	Bladder/kidney disease
☐	☐	Asthma	☐	☐	Prostate problems
☐	☐	Pneumonia	☐	☐	Bleeding
☐	☐	Stroke/Seizures/Fainting	☐	☐	Cancer
☐	☐	Diabetes	☐	☐	Psychiatric

Updated

_____

_____

PREVIOUS SURGERY:

☐ Tonsillectomy: .....(date:_____)
☐ Appendectomy: .....(date:_____)
☐ Gall bladder removal:(date:_____)
☐ Other: .....(date:_____)
☐ Other: .....(date:_____)
☐ Other: _____(date:_____)
☐ Other: _____(date:_____)

☐ Hernia: _____(date:_____)
☐ Cataract: _____(date:_____)
☐ Other: _____(date:_____)
☐ Other: _____(date:_____)
☐ Other: _____(date:_____)

HOSPITALIZATION(S):

☐ Reason(s) and date(s): _____

_____

_____

_____

_____

IN THE PAST MONTH HAVE YOU HAD:

YES	NO		YES	NO	
☐	☐	Weight loss	☐	☐	Blood in stool
☐	☐	Fever/chills	☐	☐	Black stool
☐	☐	Heat or cold intolerance	☐	☐	Frequent urination
☐	☐	Vision damage	☐	☐	Burning with urination
☐	☐	Dry eyes	☐	☐	Blood in urine
☐	☐	Excessive Tearing	☐	☐	Leaking of urine/Incontinence
☐	☐	Chest pain	☐	☐	Weakness
☐	☐	Shortness of breath	☐	☐	Numbness
☐	☐	Irregular heart beat/Palpitations	☐	☐	Stiffness of joints
☐	☐	Nausea	☐	☐	Easy bruising
☐	☐	Vomiting	☐	☐	Last menstrual period (date:_____)
☐	☐	Abdominal pain	☐	☐	Last PAP Smear .....(date:_____)
☐	☐	Change in bowel habits	☐	☐	Are you pregnant
☐	☐	Diarrhea	☐	☐	Menopause .....(date:_____)
☐	☐	Constipation	☐	☐	Bleeding since menopause

Have you ever been to a psychiatrist or psychologist? ☐Yes ☐No If yes, why? _____

_____

SOCIAL:

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Occupation: _____

☐ Tobacco use: How many Years? _____; Packs per day_____

Alcohol use:
☐ None ☐ Rarely ☐ Social ☐ Daily: _____oz. per day; _____beers per day

☐ Drug use/history: _____

FAMILY HISTORY: **Diseases that run in the family (father, mother, brother, sisters)**

_____

_____