INSTITUTE OF ADVANCED ENT SURGERY

Today's Date: ______________________________

Patient Name: Please print (if you need help filling out this form let our receptionist know)

____ Birth Date: __________ Age: ________

(First) (M) (Last)

Name of your regular Physician (s) ____

Reason for this visit: ____

PAST MEDICAL HISTORY

- Current or/past Medical Disorders: ______________________________ [ ] None
____
____
____

- Do you have any allergies or ever had adverse reactions to medications? **(please list)**
____
____
____
____

  Other allergies (hay fever, foods, latex)
____
____
____

- Have you ever had surgery? **(Please list)** [ ] No
______________________ Date: __________
______________________ Date: __________
______________________ Date: __________

- Have you ever had problems with anesthesia? [ ] Yes [ ] No

  Type of reaction: ______________________________

- Have you or family members had a blood clotting or bruising problem? [ ] Yes [ ] No

MEDICATIONS

Please list current prescription drugs: ______________________________
____
____
____
____

Please list over the counter drugs (aspirin, nose spray or herbal med; i.e. Gingko, St. John's Wort)
____
____
____
____

- ARE YOU PREGNANT? [ ] Yes [ ] No

Patient Name: ______________________ Date: ______________

II. REVIEW OF SYSTEMS - Check either "yes" or "no" in each individual area.

Yes	No	Symptom
[ ]	[ ]	gradual hearing loss
[ ]	[ ]	sudden hearing loss
[ ]	[ ]	inability to understand words
[ ]	[ ]	ringing in your ears or head
[ ]	[ ]	ear popping or clicking
[ ]	[ ]	noise in your head
[ ]	[ ]	dizziness or imbalance
[ ]	[ ]	constant ear infections
[ ]	[ ]	drainage from your ear
[ ]	[ ]	ear pain or fullness
[ ]	[ ]	ear fullness
[ ]	[ ]	vertigo (room/surroundings spinning)

Yes	No	Symptom
[ ]	[ ]	chronic tonsil infection
[ ]	[ ]	white specks on tonsils
[ ]	[ ]	sore throat
[ ]	[ ]	bad breath
[ ]	[ ]	hoarse/raspy voice
[ ]	[ ]	voice cut offs during speech
[ ]	[ ]	voice cut offs during singing
[ ]	[ ]	feeling a lump in throat
[ ]	[ ]	heartburn
[ ]	[ ]	throat clearing

Yes	No	Symptom
[ ]	[ ]	light snoring
[ ]	[ ]	load snoring
[ ]	[ ]	inability to sleep soundly
[ ]	[ ]	frequent awakenings at night
[ ]	[ ]	mouth breathing
[ ]	[ ]	choking/gasping during sleep
[ ]	[ ]	difficulty getting up in morning
[ ]	[ ]	daytime tiredness
[ ]	[ ]	falling asleep during the day
[ ]	[ ]	obstructive sleep apnea
[ ]	[ ]	morning headaches

Yes	No	Symptom
[ ]	[ ]	runny nose
[ ]	[ ]	postnasal drip
[ ]	[ ]	persistent cough
[ ]	[ ]	nosebleeds
[ ]	[ ]	nasal congestion or obstruction
[ ]	[ ]	loss of sense of smell or taste
[ ]	[ ]	sinus pain, pressure, headache
[ ]	[ ]	other headache
[ ]	[ ]	new sinus infection
[ ]	[ ]	chronic sinus infection
[ ]	[ ]	nasal or facial fracture
[ ]	[ ]	allergy aspirin
[ ]	[ ]	nasal polyps

do / did		family members ever suffer from the following?
[ ]	[ ]	hearing loss
[ ]	[ ]	ringing in the ears (tinnitus)
[ ]	[ ]	chronic ear infections
[ ]	[ ]	dizziness
[ ]	[ ]	nasal allergies
[ ]	[ ]	chronic sinus infections
[ ]	[ ]	nosebleeds
[ ]	[ ]	snoring
[ ]	[ ]	obstructive sleep apnea
[ ]	[ ]	heartburn/reflux
[ ]	[ ]	head and neck tumors

[ ] All other ROS negative

Patient Name: ______________________ Date: ______________

OTHERS

		Yes	No
Cancer (type)	______	[ ]	[ ]
Arthritis	______	[ ]	[ ]
Chemical dependency (type)	______	[ ]	[ ]
Infection requiring hospitalization?	______	[ ]	[ ]
Injury requiring hospitalization	______	[ ]	[ ]
Have you ever had a blood transfusion?		[ ]	[ ]
Have you ever been tested for HIV?		[ ]	[ ]

III. SOCIAL AND FAMILY HISTORY

Occupation: ______________________ [ ]Married [ ] Single [ ] Divorced

Do you smoke? [ ]Yes [ ]No

Packs per day _____ for _____ Years?

If you quit, how many years ago? ______

Other types of tobacco? [ ]Pipe [ ]Cigars [ ]Chew

Alcohol use - number of drinks per week. _________

Do you use recreational drugs? [ ]Yes [ ]No

Health conditions in your family including cancer, heart disease, diabetes (please list)

____

____

Physician use only: Date & Initial: