MID-MICHIGAN EAR, NOSE & THROAT

PATIENT NAME:

LAST_____FIRST_____MIDDLE INITIAL_____

DOB_____AGE_____SEX_____

PHARMACY NAME/ADDRESS:_____

REASON FOR VISIT TODAY:_____

REVIEW OF SYSTEMS - If you currently have any of the following please circle all that apply.

GENERAL

Appetite Loss Chills Fatigue Fever Weight Gain>10lbs. Weight Loss>10lbs.

SKIN

Cracked Lips Dryness Hair Loss Hives Itching New Lesions Excessive Sweating

HEAD, EYES, EARS, NOSE & THROAT

Deafness Decreased Hearing Ear Discharge Nosebleed Sore Throat

Hoarseness Nasal Congestion Visual Disturbances Choking Sensation Spinning Sensation

Ear Pain Ringing in the Ears Dry Mucous Membranes

NECK

Neck Mass Neck Pain Swollen Glands

RESPIRATORY

Cough Wheezing Difficulty Breathing Snoring

CARDIOVASCULAR

Chest Pain Difficulty Breathing Fainting/Blacking Out Irregular Heart Beat Palpitations

Edema Shortness of Breath

GASTROINTESTINAL

Abdominal Pain Heartburn Nausea Vomiting Difficulty Swallowing

MUSCULOSKELETAL

Muscle Pain Muscle Weakness

NEUROLOGICAL

Fainting Headaches Incoordination Spinning Sensation Tremor

Weakness Tingling Muscle Twitching Loss of Consciousness Numbness

PSYCHIATRIC

Anxiety Insomnia Panic Attacks Trouble Falling Asleep

ENDOCRINE

Cold Intolerance Excessive Sweating Heat Intolerance

HEMATOLOGY

Abnormal Bleeding Easy Bruising Enlarged Lymph Nodes

ALLERGIES: No Known Drug Allergies

LATEX

Iodine/IVP Dye

Drugs: (list type and reaction type)_____

Foods: (list type and reaction type)_____

MEDICATIONS

Please list all of your current medications, including over the counter medications, supplements, and prescriptions.

Medication	**Dosage**	**Frequency**

MEDICAL HISTORY – Please include (past or present) and (circle all that apply)

Allergic Rhinitis	Anemia
Arthritis	Asthma
Bleeding disorder	Cancer Date_____ Type_____
Carotid Artery Stenosis	Chronic Ear Infections
Chronic Sinusitis	Congestive Heart Failure
COPD/Emphysema	Cystic Fibrosis
Depression	Diabetes Mellitus
Glaucoma	Hearing Loss
Heartburn	Heart Attack
Heart Disease	Heart Murmur
Heart Valve Insufficiency	Hypertension/High Blood Pressure
Hospitalizations – Date_____	Reason_____
Injuries to Nose, Face and/or Head	(explain)_____
Kidney Problems	Peripheral Vascular Disease
Seizure Disorder	Sickle Cell Disease
Sleep Apnea	Stomach Ulcer or Duodenal Ulcer
Stroke/CVA	Thyroid Disease
Thyroid Nodule	Tinnitus
Vitamin D Deficiency	No Pertinent Past Medical History

Other:_____

SURGICAL HISTORY - (Circle all that apply)

Adenoidectomy Angioplasty

Cardiac Pacemaker Insertion Cardiac Stent

Defibrillator Implant Ear Surgery Type_____

Glossectomy/Tongue Hysterectomy

Laryngectomy/Voice Box Mastoidectomy

Myringoplasty Myringotomy

Myringotomy with Tube Placement Parathyroidectomy

Reduction Facial Fracture Reduction Nasal Fracture

Reduction Orbital Fracture Rhinoplasty

Sinus Surgery Spinal Fusion/Neck

Thyroidectomy – Left Thyroidectomy – Right

Thyroidectomy – Subtotal Thyroidectomy – Total

Tonsillectomy Total Hip Replacement

Tubal Ligation Tympanostomy

Valve Replacement Abdominal/Gastrointestinal

Other:_____

SOCIAL HISTORY

Alcohol Use NO YES Quantity_____

Illicit Drug Use NO YES Type & Quantity_____

Tobacco Use NO YES Type & Quantity_____

Have you been treated in the past for substance or alcohol abuse NO YES

Most recent primary occupation_____

FAMILY HISTORY – Circle all that apply and list relationship

Anesthetic Complications Bleeding Disorder Cancer Type_____

Congenital Hearing Loss Diabetes Congenital Hearing Loss

Diabetes Mellitus Heart Disease Hypertension/High BP

Lung/Respiratory Disease Stroke/CVA Thyroid Problems

No Pertinent Family History Family History Unknown

DIAGNOSTIC STUDIES – Circle any of the following studies you have had

Allergy Testing	Bone Density Study
Cardiovascular Stress Test	Coronary Angiogram
EGD/Endoscopy	EKG
PFT's/Breathing Tests	MRI Brain, Brainstem and/or Inner Ears
MRI C-Spine	MRI Neck
MRI Face and/or Orbits	CT Scan of Brain
CT Scan of Chest	CT Scan of Head
CT Scan of Neck	CT Scan Sinus
CT Scan of Temporal Bones	Ultrasound, Doppler/Carotids
Ultrasound, Thyroid	C-Spine X-Ray
Chest X-Ray	Sinus X-Ray

Please bring relevant test results and CD images to your appointment if available.

For females only

Are you currently pregnant or possibly pregnant NO YES

Are you currently breastfeeding NO YES

For children only

Any newborn/birth complications? NO YES

If yes, explain:_____

Birth Weight_____

Gestational Age_____

Pregnancy Complications NO YES Describe_____

Newborn Complications NO YES Describe_____

Newborn Hearing Screen NO YES If yes - PASS FAIL

Are immunizations up to date? NO YES