ENT CENTER OF EXCELLENCE

Personal Information

Patient Form

Patient Name: _____ DOB: _____

Medication List (Including vitamins/ supplements)	DOSE	HOW TAKEN

Medication Allergies ___ No Known Allergies

_____ _____

_____ _____

_____ _____

Problem List/ Past Medical History

__ Allergies, Environmental	__ Other	__ Glaucoma	__ Migraine
__ Allergies, Seasonal	__ Head &Neck	__ Hearing Loss	__ Obesity
__ Anemia	__ COPD	__ Heart Disease	__ Seizures
__ Anxiety	__ Coronary Artery Disease	__ Hepatitis	__ Sinusitis
__ Arthritis	__ Depression	__ High Blood Pressure	__ Sleep Apnea
__ Asthma	__ Diabetes	__ HIV/AIDS	__ Stroke
__ Cancer	__ Gastric Reflux	__ Irritable Bowel Syndrome	__ Thyroid Disease

FAMILY HISTORY:

Has any member of your family been diagnosed with any conditions heart failure, cancer, etc.(Include deceased family members)?

PAST SURGICAL HISTORY:

■ NONE

__ Anesthetic Complications	__ Craniotomy	__ Laryngectomy; Radical	__ Parathyroidectomy
__ Adenoidectomy	__ Ear Tubes	__ Mastoidectomy	__ Reduction of facial Frc
__ Appendectomy	__ Endarterectomy	__ Myringoplasty	__ Reduction of Nasal frc
__ Back Surgery	__ Glossectomy	__ Myringotomy	__ Rhinoplasty
__ Breast Surgery	__ Hypophysectomy; Partial	__ Nasal Sinustomy	__ Sinus Surgery
__ Cataract Surgery	__ Hypophyesectomy; Total	__ Nasal Surgery	__ Sleep Apnea Surg

__ Cholecystectomy __ Hysterectomy __ Neck Surgery __ Spinal Fusion Neck

__ Cosmetic Surgery __ Laryngectomy; Partial __ Ovary Removal __ Thyroid Surgery

__ Tonsillectomy

__ Tracheostomy

__ Tubal Ligation

__ Tympanpstomy

SOCIAL HISTORY:

Please describe your current tobacco use:

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Light tobacco smoker ☐ Heavy tobacco smoker

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoked ☐ Unknown if ever smoked

If you currently use tobacco or have in the past, please indicate what type (cigarettes, cigars, pipe, chew) and how many years:

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate type of beverage and how many times per week: _____

Please describe your current caffeine use: ☐ None ☐ 1-2 servings/day ☐ 2-3 servings/day ☐ 4- more serving/day

Have you used any illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of drug and how often: _____

Please describe your current Sleep: ☐ No complaints ☐ Daytime drowsiness ☐ Difficulty falling asleep ☐ Early waking ☐ Napping ☐ Using Pap Device

HEARING QUESTIONNAIRE

1.) Does a hearing problem cause you to feel embarrassed when you meet new people?

No Sometimes Yes

2.) Does a hearing problem cause you to feel frustrated when talking members of your family?

No Sometimes Yes

3.) Do you have difficulty hearing/ understanding co-workers, clients or customers?

No Sometimes Yes

4.) Do you feel handicapped by a hearing problem?

No Sometimes Yes

5.) Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?

No Sometimes Yes

6.) Does hearing problem cause you to have arguments with family members?

No Sometimes Yes

7.) Does a hearing problem cause you to have arguments with family?

No Sometimes Yes

8.) Does a hearing problem cause you difficulty when listening to TV or radio?

No Sometimes Yes

9.) Do you feel that any difficulty with your hearing limits or hampers your personal or social life?

No Sometimes Yes

10.) Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?

No Sometimes Yes

If you have guardianship over a grandchild, niece, nephew, brother, sister, or etc. we will need paper working stating you have guardianship.