ENT CENTER OF EXCELLENCE

Personal Information

First Name ________________ Middle ___ Last Name ________________

Address ______________________________________

City _____________ State __ Zip __________

Home Number _______________ Cell Number ______________

DOB ___________ Age ___ Sex M or F

Parent/ Legal Guardian _________________________ Relationship __________________

Local Pharmacy Phone _______________

Mail Order Pharmacy ___________________ Phone _______________

Reason For Seeing Doctor Today

__ Ear Pain __ Sinus Drainage __ Allergies __ Other

__ Ear Blockage __ Sinus Headache __ Thyroid/ Lymph Nodes __________

__ Ear Infection __ Sinus Congestion __ Sleep Disorder/ Apnea __________

__ Ear Drainage __ Lesions in mouth/ Tongue __ Sore Throat/ Cough __________

__ Hearing Loss

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

ENT CENTER OF EXCELLENCE

Patient Form

Patient Name: ___________________ DOB: _________________________

Medication List (Including vitamins/ supplements)	DOSE	HOW TAKEN

Medication Allergies ___ No Known Allergies

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

Environmental Allergies ___ No Known Allergies

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: ☐ Normal
- ☐ Appetite Loss
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Tiredness
- ☐ Weight Gain > 20 lbs.
- ☐ Wight Loss > 10 lbs.

Neck: ☐ Normal
- ☐ Neck Mass
- ☐ Swollen Glands
- ☐ Neck Pain
- ☐ Neck Swelling

Musculoskeletal: ☐ Normal
- ☐ Joint pain
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Fibromyalgia
- ☐ Upper Extremity Weakness

Skin: ☐ Normal
- ☐ Acne
- ☐ Bruising
- ☐ Dryness
- ☐ Excessive Sweating
- ☐ Itching
- ☐ New Lesions
- ☐ Ulcer
- ☐ Rash
- ☐ Hives

Respiratory: ☐ Normal
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ Bloody Sputum
- ☐ Chronic Cough
- ☐ Difficulty Breathing on Exertion
- ☐ Sputum Production
- ☐ Wakes up from Sleep wheezing or short of breath

Neurological: ☐ Normal
- ☐ Dizziness
- ☐ Fainting
- ☐ Facial Paralysis
- ☐ Seizures
- ☐ Migraines
- ☐ Stroke

Heent: ☐ Normal
- ☐ Ear Discharge
- ☐ Ear Infection
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Ringing In the ears
- ☐ Vertigo
- ☐ Runny Nose
- ☐ Sinusitis
- ☐ Seasonal Allergies
- ☐ Sneezing
- ☐ Nasal Congestion
- ☐ Nose Bleed
- ☐ Headache
- ☐ Glaucoma
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Choking Sensation
- ☐ Oral Ulcers

Cardiovascular: ☐ Normal
- ☐ Chest Pain
- ☐ Shortness Of Breath
- ☐ Heart Attack
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Heart Stent
- ☐ Hypertension

Gastrointestinal: ☐ Normal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Mass
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion

Psychiatric: ☐ Normal
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Memory Loss
- ☐ Change In Sleep Pattern
- ☐ Insomnia
- ☐ Trouble Falling Asleep

Endocrine: ☐ Normal
- ☐ Cold Intolerance
- ☐ Thyroid Problem
- ☐ Hair Changes

Hematology: ☐ Normal
- ☐ Anemia
- ☐ Abnormal Bleeding
- ☐ Enlarged Lymph Nodes
- ☐ Blood clots

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:

Living Situation: ☐ Lives with parents ☐ Lives with significant other ☐ Lives with relatives ☐ Lives in home healthcare environment ☐ Lives in Assisted Living Facility

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.

Do you give ENT Center Of Excellence consent to any marketing or promotional advertisement Via: Email, phone, text , mail, or etc?

☐ YES ☐ NO ☐ MAYBE IN THE FUTURE