Name: _____

ADVANCED EAR, NOSE, THROAT ASSOCIATES

NEW PATIENT MEDICAL HISTORY

Thank you for coming to see us today. To the best of your ability, we would like you to fill out this short questionnaire to better understand your problem.

Below you will find a list of medical, social, and family history questions. Except where a written response is requested, please answer "yes" or "no" for each question. Please darken in each circle completely, as they will be scanned by computer. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

Has a physician or other care provider referred you for an ENT consultation? O Yes O No
If so, who? _____

Do you have any chronic medical illnesses which require either regular medical visits or medications? O Yes O No

Social History

Do you drink alcohol? O Yes O No

Do you smoke cigarettes? O Yes O No

Do you use smokeless tobacco? O Yes O No

Family History

Are there any medical illnesses that run in your family? O Yes O No
If so, please specify: Father: _____ Mother: _____

LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO:

O codeine O erythromycin O penicillins
O sulfa O tetracycline O CT/ IVP contrast dye
Other: _____

List all medications, including aspirin, herbal medicines, vitamins, and diet pills you take on a regular basis with dosages:

_____
_____
_____
_____
_____
_____
_____
_____

Name: _____

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Past Medical History (PLEASE FILL IN ANY BUBBLE THAT APPLIES)

allergic rhinitis	O .
allergy shots?	O .
anemia	O .
anxiety/ depression	O .
arthritis	O .
asthma	O .
autoimmune disease	O .Type: _____
bleeding disorder	O .
cancer	O .Type: _____
congest. heart failure	O .
diabetes	O .
emphysema/ COPD	O .
esophageal reflux	O .
heart disease	O .
currently seeing a cardiologist	O .
hepatitis	O .
high blood pressure	O .
HIV / AIDS	O .
kidney disease	O .
leukemia/ lymphoma	O .
lung disease	O .
migraine headache	O .
neurologic disorders	O .Type: _____
osteoporosis	O .
pulmonary embolism or DVT	O .
sleep apnea	O .
stroke	O .
thyroid disease	O .
other condition	O .Type: _____

Surgical History

ear surgery	O .Type: _____
adenoidectomy	O .
tonsillectomy	O .
septoplasty	O .
sinus surgery	O .
skin cancer removal	O .
hysterectomy	O .
tubal ligation	O .
pacemaker	O .
cardiac stent	O .
open heart surgery	O .
carotid artery surgery	O .
orthopedic surgery	O .
spine surgery	O .
other surgery	O .Type: _____

Name: _____

ADVANCED EAR, NOSE, THROAT ASSOCIATES

Are you having any of these medical complaints at this time? (please answer all questions)

Allergy symptoms	O Yes	O No
Anxiety	O Yes	O No
Chest pain	O Yes	O No
Heartburn	O Yes	O No
Numbness	O Yes	O No
Rash	O Yes	O No
Voice problems	O Yes	O No
Nasal/ Sinus problems	O Yes	O No
Swallowing problems	O Yes	O No
Urinary difficulty	O Yes	O No
Muscle weakness	O Yes	O No
Heat or cold intolerance	O Yes	O No
Fever	O Yes	O No
Change in smell	O Yes	O No
Depression	O Yes	O No
Hearing loss	O Yes	O No
Poor sleep quality	O Yes	O No
Significant weight loss or gain	O Yes	O No
Visual problems	O Yes	O No
Neck pain	O Yes	O No
Swollen glands	O Yes	O No
Racing/ irregular heartbeat	O Yes	O No
Persistent cough	O Yes	O No

Height: _____ Weight (last recorded): _____

Patient Portal:

We are implementing a new patient portal to our practice where you can have access to your medical records, medical history, send messages to our office, and even request for medication refills. Please provide us with your email address if you haven't already done so:

E-mail address: _____

Thank you,

Advanced Ear, Nose, Throat Associates