PUGET SOUND EAR, NOSE & THROAT

Name: _____ Date of Birth : ___ / ___ /_____

Referring Physician:_____ Height _____ Weight _____ Date: ___ / ___ /_____

Preferred Pharmacy_____ Location_____Phone_____ Fax_____

Are you pregnant or nursing? _____ Please briefly state the reason for your visit to our offices:

_____

_____

Have you had surgery with a physician from this office in the past? ___ Yes ___ No

Race: ___ Caucasian ___African American ___Hispanic ___ Native American ___ Asian___Other: _____ Language: _____

Medication Allergies: ___ None ___ Latex Allergy

_____

_____

Current Medications: ___ None (Include over the counter and herbal medications/vitamins)

_____ Dose: _____ _____ Dose: _____

_____ Dose: _____ _____ Dose: _____

_____ Dose: _____ _____ Dose: _____

_____ Dose: _____ _____ Dose: _____

Surgical History:

_____ Date: ____ _____ Date: ____ _____ Date: ____

_____ Date: ____ _____ Date: ____ _____ Date: ____

Medical Hospitalizations:

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

YOUR Medical History:

___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Autoimmune disease
___ Birth Disorder
___ Bleeding Disorder
___ Cancer: _____
___ Chronic Infection
___ Congestive Heart Failure
___ COPD
___ Coronary Artery Disease
___ CVA (stroke)
___ Depression
___ Diabetes - type: ____
___ Emphysema
___ GERD (reflux)
___ Glaucoma
___ Graves Disease
___ Headaches
___ Heart Disease: _____
___ Hepatitis (type)
___ HIV
___ Hyperlipidemia (High Cholesterol)
___ Hypertension (High Blood Pressure)
___ Hyperthyroidism
___ Hypothyroidism
___ Intestinal Disorder
___ Irregular heart rate
___ Kidney Disorder
___ Otosclerosis
___ Seizure Disorder
___ Sleep Apnea
___ Other: _____
_____

FAMILY Medical History:

___ Allergies
___ Asthma
___ Autoimmune Disease
___ Coronary Artery Disease
___ Cancer: _____
___ Cleft lip / palate
___ CVA (Stroke)
___ Depression
___ Developmental Delay
___ Diabetes
___ GERD (Reflux)
___ Hearing Disorder
___ Hematological Disorder
___ Hyperlipidemia
___ Hypertension
___ Migraines
___ Obesity
___ Chronic Ear Infections

Name: _____ Date of Birth : ___ / ___ /_____

Social History:

DO YOU SMOKE? Y N HAVE YOU EVER SMOKED? Y N Smoking cessation pamphlets are available.

Age started?_____ Age quit?_____ Packs per day?_____ Years used?_____

Other tobacco use? _____ Recreational drug use: _____

Do you drink alcohol? _____ If yes, how many drinks do you have per week: _____

Do you drink caffeine? _____ What form?(coffee, tea, soda…) _____ How may per day? _____

Review of Systems: ***(Patient to complete)***

Constitutional: ___ all negative

___ chills ___ fever ___ fatigue ___ night sweats ___ weight gain ___ weight loss Other:_____

HEENT: ___ all negative

___ Visual disturbance ___ear pain ___ear discharge ___ hearing loss ___ difficulty swallowing

___ hoarseness ___ dizziness ___ sore throat ___ ringing in ears ___ mouth ulcers

Other: _____

Respiratory: ___ all negative

___ shortness of breath ___ wheezing ___ snoring ___ sleep apnea Other: _____

Cardiovascular: ___ all negative Cardiologist _____

___ chest pain ___ heart murmur ___ palpitations ___ pacemaker ___ defibrillator Other: _____

Gastrointestinal: ___ all negative

___ abdominal pain ___ heartburn ___ diarrhea ___vomiting ___ constipation Other: _____

Metabolic: ___ all negative

___ cold intolerance ___ heat intolerance ___ increased thirst Other: _____

Neurologic: ___ all negative

___ sleep problems: type _____

___ passing out ___ tremor ___ weakness ___ ADHD ___ Autism Other: _____

___ numbness in hands/feet ___ tingling in hands/feet

Psychiatric: ___ all negative

___ anxiety ___ depression ___ hallucinations Other: _____

Dermatologic: ___ all negative

___ Pruritis (itchy skin) ___ Rash ___ Change in mole ___ Lesion on face Other: _____

Hematologic: ___ all negative

___ Bleed easily ___ Bruise easily ___ Enlarged lymph node ___ Abnormal blood tests ___ Blood clots

Is there anything else you would like us to know regarding your health?

_____

_____

_____

If your BMI is greater than 25, you may benefit from weight loss counseling.

* **Patient / Guardian signature:** _____ **Date:** ___ / ___ / _____