Ear, Nose & Throat Associates of Charleston, Inc.
(304) 342-0124

Patient_____ _____Birth Date_____ Height_____ Weight_____

**CHIEF COMPLAINT** Why are you seeing the doctor today?

_____

_____

How long have you had this problem? _____

Have you had a similar problem? _____ If so, when? _____

## ALLERGY HISTORY

| *List each medication allergy* | *Describe Reaction* | *List each medication allergy* | *Describe Reaction* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

*Are you allergic to any of the following:*

☐ seafood ☐ peanuts ☐ latex

☐ food _____

☐ other_____

☐ environmental allergies (dust, mold, trees, etc.) _____

_____

Have you ever been treated for these? ☐ Yes ☐ No

Where _____

When_____

## YOUR PAST MEDICAL HISTORY

*(specify)*

☐ heart problems _____

☐ lung problems: ☐asthma ☐bronchitis ☐other_____

☐ high blood pressure

☐ cancer_____

☐ bleeding disorder_____

☐ stroke

☐ diabetes

☐ other_____

Have you ever had surgery? ☐ Yes ☐ No

| *Type of surgery* | *Date* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## PERSONAL HABITS

History of **tobacco** use? ☐ Yes ☐ No

☐ cigarettes ☐ cigars ☐ pipe ☐ chewing tobacco

☐ snuff *Amount used* _____

*How long?*_____ *Date Quit*_____

**Alcohol consumption** ☐ Yes ☐ No

☐ beer ☐ wine ☐ liquor_____

*How much?* _____ *How often?*_____

## FAMILY HISTORY *(parent, grandparent, brother, sister, aunt, or uncle)* Has anyone ever been diagnosed with:

*(specify)*

☐ high blood pressure

☐ heart problems _____

☐ hearing loss

☐ allergies _____

☐ cancer _____

☐ stroke

☐ diabetes

☐ asthma

☐ bleeding abnormalities_____

*(Continued on back)*

**REVIEW OF SYSTEMS:** Please indicate any personal history below (check all that apply):

### Constitutional Symptoms
- ☐ Good general health lately
- ☐ Recent weight gain: ____# loss:____#
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

### Eyes
- ☐ Eye disease or injury
- ☐ Wear glasses/contact lenses
- ☐ Blurred or double vision

### Ears/Nose/Mouth/Throat
- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Chronic sinus problem or rhinitis
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Sore throat or voice change
- ☐ Swollen glands in neck

### Cardiovascular
- ☐ Heart trouble
- ☐ Chest pain or angina pectoris
- ☐ Palpitation
- ☐ Shortness of breath w/walking or lying flat
- ☐ Swelling of feet, ankles or hands

### Respiratory
- ☐ Chronic or frequent coughs
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ History of Tuberculosis "TB"

### Gastrointestinal
- ☐ Loss of appetite
- ☐ Change in bowel movements *How?*
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Painful bowel movements or constipation
- ☐ Rectal bleeding or blood in stool
- ☐ Abdominal pain

### Urinary
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change in force of strain when urinating
- ☐ Incontinence or dribbling
- ☐ Kidney stones

### Reproductive
- ☐ Sexual difficulty
- ☐ Male - testicle pain
- ☐ Female
  - ☐ pain with periods
  - ☐ irregular periods
  - ☐ vaginal discharge
  - ☐ # of pregnancies _____
  - ☐ # of miscarriages _____
  - ☐ date of last pap smear _____

### Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty in walking

### Integumentary (skin, breast)
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge

### Neurological
- ☐ Frequent or recurring headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling sensations
- ☐ Tremors
- ☐ Paralysis
- ☐ Head injury

### Psychiatric
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

### Endocrine
- ☐ Glandular or hormone problem
- ☐ Excessive thirst or urination
- ☐ heat or cold intolerance
- ☐ Skin becoming dryer
- ☐ Change in hat or glove size

### Hematologic/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleeding or bruising tendency
- ☐ Anemia
- ☐ Phlebitis
- ☐ Past transfusion
- ☐ Enlarged glands

### Allergic/Immunologic
History of skin reactions
- ☐ Hives
- ☐ Eczema
- ☐ Dermatitis

- ☐ Anaphylaxis reaction_____

Other adverse reactions to:
- ☐ Penicillin or other antibiotics
- ☐ Morphine, Demerol, or other narcotics
- ☐ Novocaine or other anesthetics
- ☐ Aspirin or other pain remedies
- ☐ Tetanus antitoxin or other serums
- ☐ Iodine, Merthiolate or other antiseptic
- ☐ Adhesive Tape
- ☐ Other drugs/medications

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any change in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient or Guardian Date

**Reviewed with patient**

_____ _____

Physician's Signature Date