### 1. Medical History

**DO YOU HAVE OR HAVE YOU EVER HAD** (please check box)
- [ ] No Known Medical Conditions
- [ ] Anesthesia Problems (specify ______________________)
- [ ] Bleeding Disorder (specify ______________________)
- [ ] Hearing Loss
- [ ] Ear Infections
- [ ] Ruptured Ear Drum
- [ ] Sinusitis
- [ ] Facial Trauma
- [ ] Tonsillitis (chronic)
- [ ] Heart Disease
- [ ] Hypertension
- [ ] High Cholesterol
- [ ] Arrhythmia
- [ ] Other Cardiac Disorder (specify____________________)
- [ ] Asthma
- [ ] Sleep / Snoring Problems (specify__________________)
- [ ] Other Lung Disease (specify _____________________)
- [ ] Stomach Ulcers / Colitis
- [ ] GERD (Reflux)
- [ ] Other Stomach Disorder (specify____________________)
- [ ] Acute Renal Failure
- [ ] Kidney Stones
- [ ] Other Renal Disease (specify____________________)
- [ ] Musculoskeletal Disorder (specify__________________)
- [ ] Diabetes (specify_________ controlled ____________)
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Thyroid Disease (specify________________________)
- [ ] Other Endocrine Disorder (specify________________)
- [ ] Headache /Migraine
- [ ] Seizures (specify_______________________________)
- [ ] Stroke/TIAs (specify____________________________)
- [ ] Other Neurologic Disorder (specify________________)
- [ ] Anemia (Iron Deficiency, Hemolytic or Pernicious)
- [ ] Environmental Allergies
- [ ] Chicken Pox
- [ ] Immune Deficiency
- [ ] Other Allergy (specify___________________________)
- [ ] History of Cancer: Type:________________________
  - Diagnosed:______ Treatment:____________________
- [ ] Psychiatric Disorder (specify______________________)
- [ ] Do you have any other disease or condition that you think the doctor should know about?___________________

#### For Women Only

- [ ] Are you pregnant, or is there any chance that you might be pregnant?
- [ ] Are you nursing?

### 2. Specialists

List any other doctors that you see: ______________________

- ______________________
- ______________________
- ______________________
- ______________________

### 3. Surgical History

- [ ] No Surgical History

- [ ] Ear Tubes: when_______  [ ] Septoplasty: when_______
- [ ] Tonsils: when_______  [ ] Sinus Surgery: when_______
- [ ] Adenoids: when_______
- [ ] Thyroid (partial, total): when_______
- [ ] Cardiac Stent: when_______
- [ ] Coronary Artery Bypass: x________, when_______
- [ ] Joint Replacement: (specify _________): when_______

Please list any additional operations (and dates) that you have had.

- ______________________
- ______________________
- ______________________

### 4. Family History

- [ ] No Known Medical Conditions

- [ ] Anesthesia Problems (specify____________________)
- [ ] Bleeding Disorder (specify____________________)
- [ ] Hearing Loss: Relationship:____________________
- [ ] Sinusitis
- [ ] Heart Disease
- [ ] Hypertension
- [ ] High Cholesterol
- [ ] Other Cardiac Disorder (specify____________________)
- [ ] Asthma
- [ ] Other Lung Disease (specify____________________)
- [ ] GERD (Reflux)
- [ ] Other Stomach Disorder (specify____________________)
- [ ] Renal Failure
- [ ] Other Renal Disease (specify____________________)
- [ ] Rheumatoid Arthritis
- [ ] Lupus
- [ ] Musculoskeletal Disorder (specify____________________)
- [ ] Thyroid Disease (specify____________________)
- [ ] Other Endocrine Disorder (specify____________________)
- [ ] Headache /Migraine
- [ ] Seizures (specify____________________)
- [ ] Stroke/TIAs (specify____________________)
- [ ] Vertigo
- [ ] Other Neurologic Disorder (specify____________________)
- [ ] Allergy/Immune/Skin (specify____________________)
- [ ] Cancer : Type:________ Relationship:________________
  - Type:________ Relationship:________________
- [ ] Psychiatric Disorder (specify____________________)
  - ______________________
5. Social History - Adult

Occupation: □ Employed ________________(Job Title)
□ Unemployed □ Student □ Retired
Marital Status: □ Single □ Married □ Partnered
□ Divorced □ □ Widowed
Number of Children: 1 2 3 4 5 ____________
Caffeine: _______ Drinks/Day
Pets: _______________________________
Nursing Home Resident?  Yes  No
Name of Facility: _______________

Tobacco: □ Never □ Current □ Past
Quit Date: _______ Years as a Smoker_____
Packs Per Day _______
Alcohol: □ None □ Rare □ Social □ Regular
Drinks/Week: _______
Illicit Drugs: □ Yes □ No
List: ___________________________

6. Prior Testing

□□ Allergy Testing: Skin or Blood Test?  When_________
Sensitivities: _________________________________
□ CT Scan of the Sinuses or Neck
□ MRI of the Brain or Neck
□ Swallow Study
□ Ultrasound of the Neck
□ CT Scan of the Sinuses or Neck
□ MRI of the Brain or Neck
□ Swallow Study
□ Ultrasound of the Neck

7. Immunizations & Vaccines

Have you received a flu immunization for this season (Oct-Mar)
□□ Yes When__________ □□ No

Patients 65 years of age or greater:
Have you ever received a pneumonia vaccine?
□□ Yes When__________ □□ No

8. Current Symptoms

What is your main symptom? _____________________________
When did this symptom start? __________________________
How Frequent? __________ Rate the Severity (1-10)_____
Quality (eg. pain, pressure, shooting)_________________________

9. Review of Systems

DO YOU HAVE OR HAVE YOU EVER HAD (please check box)

Ear
□□ Ear Pain  R - L - Both
□□ Hearing Loss  R - L - Both
□□ Ear Drainage  R - L - Both
□□ Noises in Ear  R - L - Both

Nose
□□ Nasal Obstruction
□□ Sinus Pressure or Pain
□□ Abnormal Sense of Smell
□□ Runny Nose

Throat
□□ Sore Throat
□□ Hoarseness
□□ Snoring/Sleep Apnea
□□ Throat Clearing
□□ Swallowing Problems

Eyes
□□ Eye Pain
□□ Itching or Watery Eyes

Heart / Chest
□□ Chest Pain
□□ Dizziness
□□ Palpitations

Lungs / Respiratory
□□ Cough
□□ Shortness of Breath
□□ Coughing up Blood
□□ Wheezing

Stomach / Gastrointestinal
□□ Heartburn / Reflux
□□ Stomach Pain

Urinary
□□ Painful Urination
□□ Frequent Urination

Musculoskeletal
□□ Joint Pain/Aches
□□ Muscle Pain/Aches

Skin
□□ Itching
□□ Rash
□□ Hives

Neurology
□□ Headaches
□□ Fainting

Blood / Glands
□□ Easy Bruising
□□ Bleeding Problems
□□ Swollen Glands

Endocrine
□□ Heat / Cold Intolerance
□□ Sweating at Night

Psychiatric
□□ Anxiety or Panic
□□ Depression
### Medication List
*Please include supplements and over-the-counter medications*

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medication Allergies
*Please list the name of the medication, prescription or over-the-counter, and your reaction (Rash, vomiting, difficulty breathing, etc.)*

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penicillin</td>
<td>Rash</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pharmacy:_______________

Name:___________________

Address/Location:______________

Phone:___________________