



Ear, Nose & Throat

Surgical Associates, S.C.

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PATIENT: _____

DOB: ____/____/____ AGE: _____ DATE: _____

PAST MEDICAL HISTORY/FAMILY HISTORY

Have you, or your immediate family, had: (please circle)

Diabetes	Self	Relative	Bleeding Problems	Self	Relative
Heart Disease	Self	Relative	Anesthesia Problems	Self	Relative
High blood pressure	Self	Relative	Kidney Disease	Self	Relative
Lung/Asthma	Self	Relative	Stroke	Self	Relative
Cancer _____ (type)	Self	Relative	Other: _____	Self	Relative

List past surgeries/hospitalizations: _____

DRUG ALLERGIES NONE

Other _____
Latex Allergy YES NO

MEDICATIONS NONE

(Continue on back)

REVIEW OF SYSTEMS

ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING PROBLEMS? (PLEASE CHECK)

GENERAL

- Fever greater than 99°
- Unexplained weight loss
- Fatigue/Weakness

EYES

- Dry or itchy eyes
- Decreased vision

EARS

- Ringing or noise in the ears
- Ear Pain or drainage
- Hearing Loss

NOSE

- Blocked or runny nose
- Loss of smell
- Nose bleeds

THROAT

- Difficulty swallowing
- Painful swallowing
- Hoarse/Rough voice
- Frequent throat-clearing

LUNGS

- Chronic cough
- Coughing up blood
- Shortness of breath
- Asthma

STOMACH

- Heartburn
- Stomach pain
- Nausea or vomiting
- Bloody stools

BONES AND MUSCLE

- Arthritis
- Muscle Pain

SKIN

- Changes in mole or wart
- New skin growth

HEART

- Chest pain with activity
- Irregular heart beat

NEURO

- Change in facial muscle strength
- Loss of facial sensation
- Headaches

ALLERGY/IMMUNO

- Seasonal allergies

SOCIAL HISTORY

Do you smoke? No Yes, packs per day _____, years smoked _____ Quit

Do you drink alcohol? No Yes, number of Drinks per week _____

Occupation _____