Name: _____ Weight: _____

DOB: _____ **PATIENT INTAKE FORM** Height: _____

- **PRESENT ILLNESS**

Location of main symptom or problem (circle one or more): Ears Nose or Sinus Throat Other: _____

Describe your main symptom or problem.

_____

_____

How long have you had the problem? ☐ Days ☐ Weeks ☐ Months ☐ Years

What types of medical treatment have you had for this problem? (Circle all that apply)

None	Steroid Shots or Pills	Antihistamines (Such As Zyrtec, Claritin and Allegra)	Antibiotics- Please list: _____
Ear Drops- Which type? _____ _____		Nasal Sprays- Please list: _____ _____	_____ _____
Other: _____			

Did these treatments help? (Circle one) Yes No Somewhat

Have you had surgery for this problem or a similar problem in the past? (If so, what type of surgery and when did you have it?) _____

- **PAST MEDICAL HISTORY**

☐ Abnormal Heart Valve	☐ Cataracts	☐ Headaches	☐ Kidney Failure	☐ Skin Conditions
☐ Allergies	☐ Cirrhosis	☐ Heart Attach	☐ Lyme Disease	☐ Sleep Apnea
☐ Anemia	☐ COPD	☐ Hepatitis	☐ Mononucleosis	☐ Stomach Problems
☐ Anxiety	☐ Depression	☐ Hiatal Hernia	☐ Multiple Sclerosis	☐ Stoke
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Osteoporosis	☐ Swimmers Ear
☐ Asthma	☐ Ear Infections	☐ HIV	☐ Prostate Problems	☐ Throat Problems
☐ Autoimmune Disorder	☐ Emphysema	☐ Incontinence	☐ Reflux	☐ Thyroid Problems
☐ Bladder Problems	☐ Fibromyalgia	☐ Irregular Heartbeat	☐ Seizures	☐ Tuberculosis
☐ Bleeding Disorders	☐ Glaucoma	☐ Keloids	☐ Sinus Infections	☐ Voice Problems

☐ Cancer: (List type) _____

☐ Other: _____

- **PAST SURGICAL HISTORY**

☐ Adenoidectomy	☐ Septoplasty	☐ Ear Drum Repair	☐ Other Surgeries: _____
☐ Tonsillectomy	☐ Rhinoplasty	☐ Mastoidectomy	_____ _____
☐ Ear Tubes (#___)	☐ Sinus Surgery	☐ Heart Surgery/ Stent/ Pacemaker	_____ _____

- **ALLERGIES** Please list any medications, foods, or other substances (such as latex or tape) that the patient is allergic to.

☐ No Allergies

Allergic To	Reaction
_____	_____
_____	_____
_____	_____

- **MEDICATIONS**

Please list ALL medications (or provide list on separate paper). Please include over the counter medications.

Medication	Dose	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please Complete Back

- **FAMILY HISTORY** Check if any of these run in the family (only those related by blood):

☐ Autoimmune Disease ☐ Hearing Loss ☐ Problems with Anesthesia ☐ Cancer _____
☐ Bleeding/ Coagulation Disorder ☐ Heart Disease ☐ Thyroid Disease ☐ Other: _____
☐ Diabetes ☐ High Blood Pressure ☐ Tuberculosis _____

- **SOCIAL HISTORY**

Marital Status: ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Other
Occupation: Current- _____ Previous-_____ ☐ Retired
Noise Exposure: ☐ At Work ☐ In Military ☐ Noise from Hobbies
Tobacco: ☐ Never Smoked ☐ Current Smoker: Amount __ per day/ # years smoking __ ☐ Former: Stopped ___
Alcohol: ☐ Never Drank ☐ Drink Currently ☐ Beer ☐ Wine ☐ Liquor Amount per day__ ☐ Former: Stopped ___
Caffeine: ☐ Coffee oz. per day: __ ☐ Tea oz. per day: __ ☐ Caffeinated Soft Drinks oz. per day ☐ None

- **SPECIAL CONCERNS**

☐ Pregnant (Due: _____) ☐ Breastfeeding ☐ Taking Blood Thinners ☐ Require Antibiotics for Procedures ☐ Latex Allergy

- **REVIEW OF SYMPTOMS** Check any active symptoms.

Constitutional:
☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Loss
☐ Loss of Appetite

Cardiovascular:
☐ Chest Pain
☐ Fainting
☐ Irregular Heart

Respiratory:
☐ Shortness of Breath
☐ Cough
☐ Coughing up blood
☐ Wheezing

Eyes:
☐ Allergic Conjunctivitis
☐ Recent Change in Vision
☐ Peri-Orbital Swelling

Gastrointestinal:
☐ Trouble Swallowing
☐ Heartburn
☐ Bloody Vomiting

Integument:
☐ Changes to Existing Skin Lesion

Neurologic:
☐ Weakness
☐ Seizures
☐ Numbness

Endocrine:
☐ Heat Intolerance
☐ Cold Intolerance

Hematology/ Lymphatic:
☐ Easy Bleeding
☐ Excessive Bleeding with Previous Surgeries
☐ Easy Bruising

Head/ Ears/ Nose/ Throat:
☐ Headache
☐ Vertigo (Spinning Sensation)
☐ Dizziness
☐ Lightheadedness
☐ Recent Head Injury
☐ Sinus Pain
☐ Nasal Obstruction
☐ Nasal Congestion
☐ Nosebleeds
☐ Nasal Discharge
☐ Ear Discharge
☐ Ear Fullness
☐ Itching in Ear
☐ Ear Swelling
☐ Pressure Sensation in Ear
☐ Deviated Septum
☐ Hearing Loss
☐ Decreased Sense of Smell
☐ Snoring
☐ Oral Ulcers
☐ Oral Sores
☐ Nasal Pain
☐ Purulent Nasal Discharge
☐ Gingival Bleeding
☐ Dental Problems
☐ Dentures
☐ Neck Stiffness
☐ Neck Pain
☐ Neck Tenderness
☐ Thyroid Mass
☐ Sore Throat
☐ Breath Odor
☐ Ear Pain
☐ Pulsatile Tinnitus
☐ Ringing in Ears
☐ Roaring Sound in Ear
☐ Oral Blisters
☐ Oral White Spots
☐ Mouth Pain
☐ Dry Mouth
☐ Enlarged Tonsils
☐ Frequent Throat Cleaning
☐ Lump in Throat
☐ Hoarseness
☐ Change in Voice
☐ Difficulty Swallowing
☐ Neck Mass
☐ Swollen Glands
☐ Neck Swelling
☐ Hearing Aid/s
☐ Other: _____

Patient Signature: _____ **Date: _____**