Patient Name: _____ **Date: _____**

Date of Birth: _____

Pharmacy and Referrals

Name, Location & Telephone #:_____

Primary Care Physician's Name, Location & Telephone #: _____

Referring Physician's Name, Location & Telephone #: _____

If you are under the care of any specialists, please provide their Names, Locations, & Telephone #s:

_____

Medical History

Please check off any of the following medical conditions that you currently have:

- ☐ NONE
- ☐ Cancer: Breast
- ☐ Cancer: Leukemia (history of)
- ☐ Cancer: Lymphoma (history of)
- ☐ Cancer: Prostate
- ☐ Cancer: Skin - History of malignant Melanoma
- ☐ Cancer: Skin - Merkel cell carcinoma
- ☐ Cancer: Skin - Squamous cell carcinoma (history of)
- ☐ Cancer: Esophageal (history of)
- ☐ Cardio: Arrhythmia
- ☐ Cardio: Atrial fibrillation (history of)
- ☐ Cardio: Cardiomyopathy
- ☐ Cardio: Congestive heart failure
- ☐ Cardio: Coronary artery disease
- ☐ Cardio: Hyperlipidemia/High cholesterol
- ☐ Cardio: Hypertension/High blood pressure (history of)
- ☐ Cancer: Esophageal
- ☐ Cancer: Other _____
- ☐ Cardio: Myocardial infarction/Heart attack
- ☐ Cardio: Heart valve disorder
- ☐ Cardio Other: _____
- ☐ Endocrine: Diabetes, Type 1 (history of)
- ☐ Endocrine: Diabetes, Type 2 (history of)
- ☐ Endocrine: Pituitary adenoma or other pituitary problem
- ☐ Endocrine: Thyroid disorder
- ☐ Endocrine Other:
- ☐ GI: Barrett's esophagus
- ☐ GI: Diverticulitis
- ☐ GI: Liver Disease – Hepatitis (active)
- ☐ GI: Liver Disease: Auto-immune hepatitis
- ☐ GI: Liver - Infectious disease
- ☐ GI: Liver Disease – Cirrhosis
- ☐ GI: Inflammatory bowel disease (history of)
- ☐ GI Other: _____
- ☐ GI: Reflux/GERD
- ☐ Uro: Benign enlargement of prostate
- ☐ Uro: Renal disease (kidney failure) (history of)
- ☐ Immuno: Multiple sclerosis
- ☐ Immuno: HIV infection
- ☐ Immune system disorder
- ☐ Lymph: Anemia
- ☐ Lymph: Bleeding disorder/Hemophilia
- ☐ Lymph: Neutropenia (low white blood count)
- ☐ Lymph: Sickle cell anemia (history of)
- ☐ Lymph: Thrombocytopenic disorder
- ☐ Ortho: Arthritis
- ☐ Ortho: Spinal stenosis
- ☐ Neuro: ALS
- ☐ Neuro: Autism
- ☐ Neuro: Stroke/CVA (history of)
- ☐ Neuro: Headaches cluster
- ☐ Neuro: Headaches migraine
- ☐ Neuro: Headaches Muscular tension
- ☐ Neuro: Headaches (specify type)_____
- ☐ Neuro: Seizures
- ☐ Ophth: Blindness
- ☐ Ophth: Macular degeneration
- ☐ Ophth: Cataracts
- ☐ Ophth: Glaucoma
- ☐ Ophth: Retinal detachment
- ☐ Psych: Anxiety (history of)
- ☐ Psych: Bipolar disorder
- ☐ Psych: History of depression
- ☐ Pulm: Asthma
- ☐ Pulm: Bronchiectasis
- ☐ Pulm: Chronic obstructive pulmonary disease (COPD)
- ☐ Pulm: Cystic fibrosis
- ☐ Pulm: Obstructive sleep apnea (OSA)
- ☐ Pulm: Pulmonary embolism
- ☐ Rheum: Arthritis
- ☐ Rheum: Autoimmune disorder (specify type) _____
- ☐ Rheum: Fibromyalgia
- ☐ Rheum: Gout
- ☐ Rheum: Lupus
- ☐ Rheum: Sjorgren's syndrome
- ☐ Vasc: Peripheral artery disease
- ☐ Systemic sclerosis
- ☐ Suspected head & neck cancer
- ☐ Other: _____

Name: _____

Surgical History

Please tell us about your surgical history. Check all that apply.

- ☐ NONE
- ☐ Abdominal/GI: Bariatric surgery (specify type)
- ☐ Abdominal/GI: Colectomy (history of)
- ☐ Abdominal/GI: Other
- ☐ Brain: Ventriculoperitoneal shunt
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Breast: Other
- ☐ Heart: Coronary artery bypass surgery
- ☐ Heart: Mechanical heart valve replacement
- ☐ Heart valve graft
- ☐ Heart: Pacemaker
- ☐ Heart: Other
- ☐ Lymph: Lymph node biopsy (specify location)
- ☐ Lymph: Lymph node excision
- ☐ Lymph: Other _____
- ☐ Ophth: Cataract surgery
- ☐ Ophth: Retinal detachment repair
- ☐ Skin: Melanoma excision
- ☐ Skin: MOHs surgery
- ☐ Skin: Skin biopsy
- ☐ Skin: Squamous cell carcinoma excision
- ☐ Vascular: Carotid endarterectomy
- ☐ Liver: Liver transplant
- ☐ Splenectomy (history of)
- ☐ Other: _____

Name: _____

ENT History

*Please check off any of the following procedure you have had and **provide date of procedure**:*

ENT Disease History

- ☐ None
- ☐ Cancer: Head and neck Cancer - specify location:
- ☐ Cancer: Melanoma of head & neck
- ☐ Cancer: Sinus
- ☐ Cancer: Skin - other type - specify
- ☐ Ear: Acoustic neuroma
- ☐ Ear: Cholesteatoma
- ☐ Ear: Eustachian tube disorder
- ☐ Ear: Hearing loss (history of)
- ☐ Ear: Mastoiditis
- ☐ Ear: Other _____
- ☐ Ear: Otitis externa (swimmer's ear)
- ☐ Ear: Otitis media (middle ear infection)
- ☐ Ear: Vertigo
- ☐ General: Facial bone fracture (history of)
- ☐ Larynx/trachea: Papillomas
- ☐ Larynx/trachea: Tracheal stenosis
- ☐ Larynx/trachea: Vocal cord paralysis
- ☐ Larynx/trachea: Vocal cord polyp
- ☐ Larynx/trachea: Respiratory papillomatosis - recurrent
- ☐ Larynx: Other _____
- ☐ Nasal: Deviated nasal septum
- ☐ Nasal: Loss of smell
- ☐ Nasal: Broken nose
- ☐ Nasal: Nasal airway obstruction
- ☐ Nasal: Other _____
- ☐ Nasal: Polyps
- ☐ Nasal: Rhinitis (allergies)
- ☐ Nasal: Septal perforation
- ☐ Nasal: Sinusitis
- ☐ Neck: Branchial cleft cyst
- ☐ Neck: Neck mass
- ☐ Neck: Other _____
- ☐ Neck: Parotid gland tumor
- ☐ Neck: Salivary stone
- ☐ Neck: Sialoadenitis (infected or inflamed salivary gland)
- ☐ Neck: Thyroglossal duct cyst
- ☐ Neck: Thyroid nodules
- ☐ Oral: other _____
- ☐ Oral: Sleep apnea
- ☐ Oral: Tonsillitis
- ☐ Other: _____

ENT Surgical History

- ☐ None
- ☐ Ear: Acoustic neuroma removal
- ☐ Ear: Mastoidectomy
- ☐ Ear: Myringotomy and tubes (specify ear)
- ☐ Ear: Myringotomy (specify ear) ____
- ☐ Ear: Prominent or protruding ear repair
- ☐ Ear: Stapedectomy
- ☐ Ear: Tympanoplasty (repair ear drum)
- ☐ Ear: Other – specify _____
- ☐ Head and neck: Parotidectomy
- ☐ Head and neck: Submandibular gland excision
- ☐ Head and neck: Thyroglossal duct cyst excision
- ☐ Head and neck: Thyroid gland excision
- ☐ Head and neck: Tracheotomy
- ☐ Nose: Balloon sinuplasty
- ☐ Nose: Endoscopic sinus surgery
- ☐ Nose: Nasal fracture repair
- ☐ Nose: Other – specify _____
- ☐ Nose: Rhinoplasty
- ☐ Nose: Septoplasty
- ☐ Nose: Turbinate reduction
- ☐ Throat: Adenoidectomy
- ☐ Throat: Other – specify _____
- ☐ Throat: Sleep apnea surgery - Uvulopalatopharyngoplasty (UPPP)
- ☐ Throat: Tonsillectomy
- ☐ Other: _____

Name: _____

ENT Family History

- ☐ None
- ☐ Otitis Media
- ☐ Sinusitis
- ☐ Smoking
- ☐ Thyroid Cancer
- ☐ Thyroid Disease
- ☐ Other _____

ENT Pediatric History

- ☐ None
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Otitis Media
- ☐ Other _____

Medications

Please list all medications you are currently taking:

Drug: _____ Dosage: _____ Frequency: ____ Drug: _____ Dosage: _____ Frequency: ____

Drug: _____ Dosage: _____ Frequency: ____ Drug: _____ Dosage: _____ Frequency: ____

Drug: _____ Dosage: _____ Frequency: ____ Drug: _____ Dosage: _____ Frequency: ____

Allergies

Please list all known allergies (environment, drug, food), as well as the type of reaction and level of severity:

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Name: _____

Social History

Smoking Status:

- ☐ NEVER
- ☐ Former Smoker
- ☐ Light Tobacco Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Current Some Day smoker
- ☐ Current Everyday Smoker
- ☐ Cigar Smoker
- ☐ Chewing Tobacco User

If applicable:

When did you start smoking? _____ Number of packs per day: _____

When did you quit smoking? _____ Total number of years smoking: _____

Alcohol Consumption:

- ☐ None
- ☐ Less than 1 Drink per Day
- ☐ 1-2 Drinks per Day
- ☐ 3+ Drinks per Day
- ☐ Other: _____

Other details:

- ☐ Drug Use _____
- ☐ IV Drug Use _____

Employer & Occupation: _____

Place of Residence: _____

Family History

Please list any family history of illness or disease:

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Disease/Illness: _____ Relation: _____ Deceased? Yes No

Let us know if there is anything else you would like to disclose:

_____