

LAKESIDE ENT & ALLERGY

Name: _____ **Date of Birth:** __/__/__ **Date of Visit:** __/__/__

Age: _____ **M / F** Referring Physician: _____ Primary Physician: _____

History of Present Illness: (What is the reason for today's visit?)

Is this a new complaint? YES NO **Women:** Are you, or could you, be pregnant? YES NO

Allergies to Medicines: (please specify reaction)

- | | | |
|----|----|----|
| 1) | 4) | 7) |
| 2) | 5) | 8) |
| 3) | 6) | 9) |

Food Allergies: _____ **Latex Allergy** YES NO

Medications: Give doses of all Rx and OTC meds, vitamins & dietary supplements (may use back)

- | | | |
|----|-----|-----|
| 1) | 6) | 11) |
| 2) | 7) | 12) |
| 3) | 8) | 13) |
| 4) | 9) | 14) |
| 5) | 10) | 15) |

Do you take aspirin, ibuprophen, or blood thinners? YES NO

Past Medical History: (may use back)

<u>Illnesses or Surgery</u>	<u>Date</u>	<u>Illness or Surgery</u>	<u>Date</u>
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Social History: single married div sep Occupation: _____

Smoking (now) YES NO (past) YES NO How much? _____ How many years? _____

(circle) cigarettes cigars pipe chewing tobacco recreational drugs

Alcohol YES NO What kind? _____ How much per day? _____ per week? _____

Family History: Diseases that run in your family (please circle)

Diabetes Heart Disease Cancer High blood Pressure Allergies Kidney disease

Hemophilia Bleeding disorders Thyroid disease Hearing loss Reactions to anesthesia

Relationship	Age	Condition	Alive/Deceased	Cause of Death

Review of Systems: Do you have any of the following symptoms or problems? **(please circle)**

General: Fever chills aches/pains memory loss nausea vomiting headaches

Skin: Growths on face, neck or scalp? YES NO Any change in size? YES NO Bleeding? YES NO

Eyes: Double vision wear glasses loss of vision cataracts eye pain itchy eyes

Ears: Buzzing or ringing itching pain pressure popping drainage dizziness hearing loss
Do you wear hearing aids? R L Ear infections in last 12 months _____
Noise exposure? Yes No Gun or firearms use? Yes No Do you wear ear protection? Yes No

Nose: Nasal discharge (color: yellow green clear) sinus heaches facial pain nosebleed
Difficulty breathing through nose? YES NO Nasal Fracture SNORING mouth breathing

Mouth: Oral lesions ulcers bleeding gums dental caviities chipped or loose teeth
Pain on opening/closing TMJ problems bad breath tongue pain tongue lesions

Throat: Sore throat pain on swallowing enlarged tonsils tonsil infections difficulty swallowing
Food getting stuck lump sensation in throat hoarseness coughing up blood

Neck: Difficulty turning your neck swollen glands lumps pain

Lungs: Asthma emphysema pneumonia bronchitis coughing SLEEP APNEA

Heart: High blood pressure chest pain murmur valve disease heart attack cardiac surgery/stents

GI: Heart burn hiatial hernia diarrhea blood in stool ulcers hepatitis nausea / vomiting

GU: Urinary tract infections burning blood in urine kidney stones

Blood: Easy bruising bleeding disorders sickle cell trait/disease anemia

Musculoskeletal: broken bones arthritis loss of muscle strength painful joints bad back or neck

Neurological: head injury concussion stroke mini-stroke migraines headaches seizures neuralgias

Psychological: depression anxiety mood disorders other psychological issues:

Endocrine: diabetes weight gain/loss hot or cold intolerance sweating nervousness
thyroid/parathyroid disease goiter/thyroid mass thyroid surgery iodine treatment radiation exposure

Other (comments & additions):

Patient Signature: _____ **Date:** __/__/____

(For Office Use Only)

Notes