PATIENT DATA BASE

_____ _____ _____
Last Name **First Name** **Middle Name**

_____ **Date of Birth:** _____ _____ _____
Age **Month** **Day** **Year**

Referred by _____ **Doctor**_____

Reason for Visit:_____

E.N.T. HISTORY: Have you had any of the following? (circle)

EARS obstruction pressure hearing loss
ringing dizziness infections drainage popping
duration of symptoms

NOSE obstruction snoring sneezing discharge
bleeding post nasal drainage dryness allergies
itchy eyes watery eyes red eyes
duration of symptoms

SINUS pain swelling pressure infections
headaches drainage
duration of symptoms

THROAT itching swelling infections soreness
painful swallowing difficult swallowing
duration of symptoms

LARYNX voice change hoarseness heartburn
heartburn belching
duration of symptoms

MEDICATIONS: Please list all over the counter and prescribed drugs that you are taking.

_____ _____
_____ _____
_____ _____

DRUG/FOOD ALLERGIES:_____

MEDICAL HISTORY: Have you had any of the following? (circle)

Hives	High Blood Pressure	Drug Dependency	Thyroid Problems	Tuberculosis
Asthma	Stroke	Mental Illness	Weight Loss	Arthritis
Hay Fever	Cancer	Alcoholism	Diabetes	Epilepsy
Shortness of Breath	Abnormal Lump/Node	Nervousness	Anemia	Seizures
Allergies	Change in Bowel Habits	Back Trouble	Menstrual Disorder	Liver Disease
Eczema	Abdominal Pain	Migraines	Easy Bruising/Bleeding	Jaundice
Chest Pain	Depression	Glaucoma	Prostate Trouble	Hepatitis
Heart Trouble	Suicidal Thoughts/Attempts	Cataracts	Coughing up Blood	AIDS, HIV

Other_____

SURGICAL HISTORY: Have you ever had any of the following? (circle)

Tonsillectomy	no	yes_____year	Nasal Surgery	no	yes_____year
Adenoidectomy	no	yes_____year	Ear Surgery	no	yes_____year
Ear Tubes	no	yes_____year	Neck Surgery	no	yes_____year
Sinus Surgery	no	yes_____year	**Other** Surgery	no	yes_____year
Laryngoscopy	no	yes_____year	_____	no	yes_____year
Thyroidectomy	no	yes_____year	_____	no	yes_____year

FAMILY HISTORY: Has any blood relative ever had: (circle)
Anesthesia Problems Bleeding Tendencies Hearing Loss Cancer Diabetes Heart Disease Anemia
Cleft Lip/Palate Asthma High Blood Pressure Allergies

SOCIAL HISTORY: Please answer.

Smoker	no	yes	How many per day _____ How long _____ Quit _____
Alcohol	no	yes	How many ounces per day _____ How long _____
Caffeine	no	yes	How many cups per day _____ How long _____