SOUTHWEST IDAHO
ENT
Ear Nose and Throat, P.A.

# ADULT

*Patient's Name:* ______________________ *D.O.B.* __________

*Referring Physician:* ______________________

*For Women:* Are you pregnant now? ☐ Yes ☐ No ☐ Possibly/Not Sure

*Name and Location of Pharmacy Used:* ______________________

*What are you seeing the doctor for today?* ______________________

***List all current medications, including any over the counter (OTC) medications or supplements.***
*(If needed, please provide on separate sheet.)*

☐ Not taking any medications

| NAME OF MEDICATION | DOSAGE |
|---|---|
| | |
| | |
| | |

*List any drug allergies or medicines you can not take*

☐ No known drug allergies

| NAME OF MEDICATION | TYPE OF REACTION |
|---|---|
| | |
| | |
| | |

*Do you have a known allergy to any of the following?* ☐ None

☐ Latex ☐ Iodine ☐ Tape ☐ Contrast Agents (Dye) ☐ Other ______________
(Please describe)

☐ Describe reaction ______________________

## Allergies

☐ None
☐ Dust
☐ Moldy Places
☐ Pollen
☐ Cut Grass
☐ Animals
☐ Exercise
☐ Foods
☐ Smoke/Fumes
☐ Outside in Spring and/or Fall
☐ Outside on Windy Days
☐ Air Conditioning

## Allergy Testing

☐ Never Done
☐ Skin Blood
☐ Negative
☐ Where Testing Done
______________________

## Allergy Injections

☐ Never Done
☐ In the Past
☐ Currently

## Other Allergies/Problems Not Listed

☐ ______________
☐ ______________
☐ ______________
☐ ______________
☐ ______________
______________
______________
______________
______________
Please Describe

# Past Health History

*Please indicate any diseases or problems that you have had or been diagnosed with by a doctor*

❑ No Major Illnesses

1. Childhood Diseases
   - ❑ Mumps
   - ❑ Measles
   - ❑ Chicken Pox
   - ❑ Other ___________
2. Cancer
   - ❑ Lung Cancer
   - ❑ Breast Cancer
   - ❑ Skin Cancer
   - ❑ Leukemia
   - ❑ Other ___________
3. Congenital (Birth) Problems
   - ❑ Down's Syndrome
   - ❑ Heart Defect
   - ❑ Prematurity (# of weeks ____)
   - ❑ Other ___________
4. Ears
   - ❑ Chronic or Frequent Infection
   - ❑ Fluid
   - ❑ Hearing Loss
   - ❑ Vertigo
   - ❑ Other ___________
5. Nose and Sinuses
   - ❑ Chronic Sinusitis
   - ❑ Deviated Septum
   - ❑ Nasal Polyps
   - ❑ Allergies
   - ❑ Other ___________
6. Mouth and Throat
   - ❑ Chronic Tonsillitis
   - ❑ Cleft Palate
   - ❑ Sleep Apnea
   - ❑ Other ___________
7. Heart
   - ❑ Atrial Fibrillation
   - ❑ Chest Pain / Angina
   - ❑ Heart Attack
   - ❑ High Blood Pressure
   - ❑ Mitral Valve Prolapse
   - ❑ Heart Murmur
   - ❑ Pace Maker
   - ❑ Other ___________
8. Lungs
   - ❑ Asthma
   - ❑ COPD / Emphysema
   - ❑ Cystic Fibrosis
   - ❑ Other ___________
9. Digestive
   - ❑ GERD / Reflux
   - ❑ Hepatitis
   - ❑ Diverticulitis
   - ❑ Hemorrhoids
   - ❑ Other ___________
10. Skin
    - ❑ Eczema
    - ❑ Psoriasis
    - ❑ Acne
    - ❑ Other ___________
11. Neurologic
    - ❑ Headaches
    - ❑ Stroke
    - ❑ Multiple Sclerosis
    - ❑ Other ___________
12. Glands & Hormones
    - ❑ Diabetes
    - ❑ Thyroid Problem
    - ❑ Other ___________
13. Blood Disorder
    - ❑ Low White Blood Cells
    - ❑ Bleeding Disorder
    - ❑ Anemia
    - ❑ Low Platelets
    - ❑ Other ___________
14. Immune Disorder
    - ❑ Rheumatoid Arthritis
    - ❑ Sjogrens
    - ❑ CREST
    - ❑ HIV
    - ❑ Other ___________
15. Psychiatric History
    - ❑ Depression
    - ❑ Anxiety
    - ❑ Mania
    - ❑ Schizophrenia
    - ❑ Other ___________

*History of any other condition not listed?* ___________________________

# Surgeries / Injury

*Have you ever had problems with anesthesia (being put to sleep for surgery)?* ❑ No ❑ Yes What problem ___________

*Indicate any major surgeries (if you choose OTHER please describe)*

❑ No Surgery

| | |
|---|---|
| Eyes | ❑ Cataract ❑ Eyelid Surgery ❑ Tear Duct ❑ Lasik ❑ Other: |
| Ears | ❑ Tubes ❑ Ear Drum ❑ Mastoid ❑ Other: |
| Nose | ❑ Septoplasty ❑ Rhinoplasty ❑ Sinus Surgery ❑ Other: |
| Throat | ❑ Adenoidectomy ❑ Tonsillectomy ❑ Other: |
| Neck | ❑ Thyroidectomy |
| Heart | ❑ Angioplasty ❑ Bypass ❑ Valve ❑ Stent ❑ Other: |
| Digestive | ❑ Appendectomy ❑ Gallbladder ❑ Hiatal Hernia ❑ Other: |
| Female Health | ❑ Hysterectomy ❑ Ovary Removal ❑ Other: |
| Other | ❑ Any other major surgery: |

*Serious injury?* ❑ No ❑ Yes ___________________________
Please Describe

# Family History

❑ Family History Unkown

*Do any of your BLOOD RELATIVES have a history of:*

- ❑ Problems with Anesthesia
- ❑ Hearing Loss after age 20
- ❑ Hearing Loss before age 20
- ❑ Heart Problems
- ❑ Bleeding / Clotting Problems
- ❑ Cancer
- ❑ Other Major Health Problems

___________________________
Please Describe

❑ No family history problems known

# Social History

Current Occupation: ___________________________ ❑ Retired ❑ Student **Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Tobacco Use: ❑ Never ❑ Quit ❑ Yes: ❑ Cigarette ❑ Cigar ❑ Pipe ❑ Chew

*How many per day?* ________

*When did you start?* Age: ______ or Year: ______ *When did you stop?* Age: ______ or Year: ______

Alcohol Use: ❑ Yes ❑ No

*How many drinks per week on average?* ________

Have you ever been dependent on or addicted to any drugs? ❑ Yes ❑ No

Patient Name: ______________________ Date of birth: ______________

## Tests and Immunizations

If you are not sure of the exact date of the test/procedure/immunization (month and day are not necessary), please list at least the year to the best of your recollection.

1. If you are a female patient between the ages of 24-64yo, when was your most recent Cervical CA screening (pap test)? N/A or date: ______________

2. If you are a female patient between the ages of 42-69yo, when was your most recent Breast CA screening (mammogram)? N/A or date: ______________

3. If you are a patient between the ages of 50-75yo, when was your most recent Colorectal CA screening (Colonoscopy, Sigmoidoscopy or FOBT)? N/A or date: ______________

4. If you are a patient 65yo or older, when was your most recent pneumonia vaccination administered? N/A or date: ______________

5. If you are a patient 6 months and older, when was your most recent influenza immunization administered? N/A or date: ______________

Patient Signature: ______________________________

Date: ______________

# Review of Systems / Symptoms

*Please indicate any other symptoms that you have now or have had in the RECENT past.*

**General**

- ❑ None
- ❑ Fever
- ❑ Sleeping Problems
- ❑ Unintentional Weight Loss

**Allergy Symptoms**

- ❑ None
- ❑ Dust
- ❑ Moldy Places
- ❑ Pollen
- ❑ Cut Grass
- ❑ Animals
- ❑ Exercise
- ❑ Foods
- ❑ Smoke/Fumes
- ❑ Outside in Spring and/or Fall
- ❑ Outside on Windy Days
- ❑ Air Conditioning

**Allergy Testing**

- ❑ Never Done
- ❑ Skin Blood
- ❑ Negative
- ❑ Where Testing Done

______________________

**Allergy Injections**

- ❑ Never Done
- ❑ In the Past
- ❑ Currently

**Other Allergies/Problems Not Listed**

- ❑ ______________________
- ❑ ______________________
- ❑ ______________________
- ❑ ______________________
- ❑ ______________________

______________________
______________________
______________________
______________________
Please Describe

**Facial / Eye Problems**

- ❑ None
- ❑ Headaches
- ❑ Facial Pain
- ❑ Facial Weakness
- ❑ Vision Changes Not Corrected by Glasses
- ❑ Other Facial or Eye Problems:

______________________
Please Describe

**Ear Problems**

- ❑ None
- ❑ Ear Pain
- ❑ Ear Drainage
- ❑ Hearing Loss
- ❑ Dizziness
- ❑ Ringing in Ears (Tinnitus)
- ❑ Other Ear Problems:
- ❑ Infection
- ❑ Pressure

______________________
Please Describe

**Nose Problems**

- ❑ None
- ❑ Nasal Obstruction
- ❑ Nasal Congestion
- ❑ Bleeding from Nose
- ❑ Sinus Drainage
- ❑ Other Nose Problems:

______________________
Please Describe

**Mouth Problems**

- ❑ None
- ❑ Voice Change / Hoarseness
- ❑ Loud Snoring
- ❑ Sore Throat
- ❑ Trouble Swallowing
- ❑ Other Mouth Problems:

______________________
Please Describe

**Neck Problems**

- ❑ None
- ❑ Neck Mass
- ❑ Other Neck Problems:

______________________
Please Describe

**Heart Problems**

- ❑ None
- ❑ Chest Pain
- ❑ Lightheadedness
- ❑ Other Heart Problems:

______________________
Please Describe

______________________
Cardioligist

**Lung Problems**

- ❑ None
- ❑ Frequent Cough
- ❑ Difficulty Breathing
- ❑ Other Lung Problems:

______________________
Please Describe

**Stomach / GI Problems**

- ❑ None
- ❑ Abdominal Pain
- ❑ Heart Burn / Indigestion
- ❑ Other Stomach / GI Problems:

______________________
Please Describe

**Urinary or Female Health Problems**

- ❑ None
- ❑ ______________________

Please Describe

**Bone / Muscle Problems**

- ❑ None
- ❑ Painful Joints
- ❑ Other Bone / Muscle Problems:

______________________
Please Describe

**Breast or Skin Problems**

- ❑ None
- ❑ ______________________

Please Describe

**Brain or Nerve Problems**

- ❑ None
- ❑ Change in Smell
- ❑ Change in Taste
- ❑ Numbness
- ❑ Weakness
- ❑ Other Brain or Nerve Problems:

______________________
Please Describe

**Blood or Lymph Problems**

- ❑ None
- ❑ Excessive Bleeding
- ❑ Other Blood or Lymph Problems:

______________________
Please Describe

**Immune Problems**

- ❑ None
- ❑ Unusual Infections
- ❑ Other Immune Problems:

______________________
Please Describe

**Other Medical Problems Not Listed**

- ❑ ______________________ ______________________
- ❑ ______________________ ______________________
- ❑ ______________________ ______________________

Please Describe