

Ear, Nose and Throat Clinic of the Northwest

Patient name: _____ Date: _____

Reason for today's visit: _____

What surgery have you had? When? _____

Please list medications you now take: _____

Please list medications you are allergic to: _____

Do you use tobacco? **Y : N** What type? _____ How much? _____ When did you start? _____ If quit, when? _____

Do you drink alcohol? **Y : N** How much: _____ Could you be pregnant now? **Y : N : Not sure : N/A**

Have you had a heart attack? **Y : N** How long since? _____

Would you like information about our full service hearing aid program or other hearing aid assistance? **Y : N**

Have you suffered from or been treated by a doctor for any of these conditions/difficulties recently (within the last 3 months)?

General		Neck		Hematology	
chills	Y : N	painful neck swelling	Y : N	bleeding/clotting difficulties	Y : N
fatigue	Y : N			bruising	Y : N
fever	Y : N	Lymph		Psychiatric	
night sweats	Y : N	enlarged lymph "glands"	Y : N	depression	Y : N
Ears		Respiratory		anxiety	Y : N
hearing loss	Y : N	cough	Y : N	Sleep	
sensitivity to loud sound	Y : N	shortness of breath	Y : N	snoring	Y : N
ringing ears/tinnitus	Y : N	coughing/spitting up blood	Y : N	gasping/choking during sleep	Y : N
recurrent ear infection	Y : N	wheezing	Y : N	Surgery	
Eyes		mucus production	Y : N	anesthesia problems	Y : N
double vision	Y : N	Cardiology		Neurological	
eye pain	Y : N	palpitations	Y : N	dizziness	Y : N
sensitivity to light	Y : N	chest pain	Y : N	fainting	Y : N
vision changes	Y : N	leg swelling	Y : N	frequent headache	Y : N
Nose		GI		light-headedness	Y : N
nosebleeds	Y : N	nausea/vomiting	Y : N	loss of memory	Y : N
recurrent sinus infection	Y : N	heartburn or belching	Y : N	weakness or paralysis	Y : N
allergy symptoms	Y : N	abdominal pain	Y : N	seizures	Y : N
Mouth		hepatitis or jaundice	Y : N		
altered sense of taste	Y : N	Musculoskeletal			
Throat		arthritis	Y : N		
hoarseness	Y : N				
freq. sore throat/tonsillitis	Y : N				
difficult swallowing	Y : N				

Medical History—Have you ever suffered from these problems?

tuberculosis	Y : N	kidney disease	Y : N	asthma	Y : N
cancers	Y : N	liver disease	Y : N	COPD	Y : N
diabetes	Y : N	stroke	Y : N	history of pneumonia	Y : N
heart disease	Y : N	thyroid disorders	Y : N	other _____	
high blood pressure	Y : N	high cholesterol	Y : N		

Family History—Has anyone in your blood related family suffered from these problems?

tuberculosis	Y : N	anesthesia problems	Y : N	liver disease	Y : N
cancers	Y : N	chronic ear infection	Y : N	respiratory disease	Y : N
diabetes	Y : N	chronic sinus infection	Y : N	stroke	Y : N
heart disease	Y : N	kidney disease	Y : N	thyroid disorders	Y : N
high blood pressure	Y : N	hearing loss	Y : N	allergy	Y : N
bleeding problems	Y : N	snoring or sleep apnea	Y : N	other _____	