Welcome to ENT of Georgia. Our goal is to provide you and your family with the highest of care. The first step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete all pages of the form below. Our staff would be glad to help you if necessary. The care we give you can be no better than the information you provide.

Name: _____ Age: _____ Date of Birth: _____
First MI Last MM/DD/YYYY

Name of Doctor you are scheduled to see: _____

Who sent you to us today? _____

This person is: ☐ Primary Physician
☐ Other Physician
☐ Non-physician health care provided
☐ Friend/Other

Gender: ☐ Male ☐ Female

Primary physician (name and phone number)
_____
_____

Please name the major problem or symptom that brings you to us today:

_____
_____

Please describe the history of your present illness in detail:

_____
_____
_____
_____
_____
_____

- Rate the severity of **today's** symptoms on a 1 – 10 scale (10 = worst): _____
- How long have your symptoms been present? _____
- What makes your symptoms worse **or** better? _____
- What other providers have you seen for this illness? _____
- What diagnostic tests have been performed so far? (please check any that applies)
  - ☐X-Ray
  - ☐CT Scan
  - ☐MRI
  - ☐Ultrasound
  - ☐Swallow Study
  - ☐Allergy Testing
  - ☐Hearing Test
  - ☐Biopsy
  - ☐OTHER _____

Reviewed by: _____

- What treatments have been tried so far (include operations done for this illness)?
  (Please check any that applies)
  - ☐Antibiotics
  - ☐Allergy Medications
  - ☐Reflux Medications
  - ☐Pain Medications
  - ☐Other _____

Please check **YES** or **NO** for those symptoms below which apply to **YOU**:

	YES	NO		YES	NO		YES	NO
Severe headache	☐	☐	Nosebleed	☐	☐	**NONE**	☐	☐
Failing vision	☐	☐	Loss of smell/taste	☐	☐	Cough	☐	☐
Eye pain	☐	☐	Hearing loss	☐	☐	Hoarseness	☐	☐
Double vision	☐	☐	Ringing in ears	☐	☐	Heartburn	☐	☐
Nasal congestion	☐	☐	Ear pain	☐	☐	Neck mass/swollen glands	☐	☐
Facial pain	☐	☐	Ear drainage	☐	☐	Snoring	☐	☐
Nasal discharge	☐	☐	Dizzy/off balance	☐	☐	Stop breathing during sleep	☐	☐
Post-nasal drip	☐	☐	Ear fullness/pressure	☐	☐	Sleepy in the daytime	☐	☐
Frequent sneezing	☐	☐	Difficulty swallowing	☐	☐	Throat Pain	☐	☐
Nasal obstruction	☐	☐	Can't clear throat	☐	☐	Neck Pain	☐	☐

Review of Systems:

Please check **YES** or **NO** for those symptoms below which apply to **YOU,** and you are **CURRENTLY** experiencing.

	YES	NO		YES	NO		YES	NO
GENERAL:			**GASTROINTESTINAL:**			**NEUROLOGIC:**		
Fever/Chills	☐	☐	Abdominal pain	☐	☐	Weakness	☐	☐
Weight loss	☐	☐	Bloody/black stool	☐	☐	Shaking/tremor	☐	☐
Night sweats	☐	☐	Nausea/vomiting	☐	☐	Fainting	☐	☐
NONE	☐	☐	Diarrhea	☐	☐	**NONE**	☐	☐
			Yellow jaundice	☐	☐			
EYES:			Indigestion	☐	☐	**PSYCHOLOGICAL:**		
Light bothers eyes	☐	☐	**NONE**	☐	☐	High stress	☐	☐
Irritated eyes	☐	☐				Depression	☐	☐
Eyes crust/drain	☐	☐	**GENITOURINARY:**			Mood swings	☐	☐
NONE	☐	☐	Weak urine stream	☐	☐	**NONE**	☐	☐
			Painful urination	☐	☐			
CARDIOVASCULAR:			Blood in urine	☐	☐	**ENDOCRINE:**		
Chest pain	☐	☐	**NONE**	☐	☐	Cold intolerance	☐	☐
Irregular heartbeat	☐	☐				Heat intolerance	☐	☐
NONE	☐	☐	**MUSCULOSKELETAL:**			Frequent thirst	☐	☐
			Painful/swollen joints	☐	☐	**NONE**	☐	☐
RESPIRATORY:			Back pain	☐	☐			
Shortness of breath	☐	☐	**NONE**	☐	☐	**BLOOD:**		
Wheezing	☐	☐				Anemia	☐	☐
Cough up blood	☐	☐	**SKIN:**			Prolonged bleeding	☐	☐
NONE	☐	☐	Rash	☐	☐	Bruise easily	☐	☐
			Flaking/peeling skin	☐	☐	HIV Risk Factors	☐	☐
			Hair/nail problems	☐	☐	**NONE**	☐	☐
			Itchy skin	☐	☐			
			NONE	☐	☐			

Reviewed by: _____

Past Medical History

Please check **YES** or **NO** for those illnesses you **have** or **have had in the past.**

	YES	NO
Glaucoma	☐	☐
Cataract	☐	☐
Macular degeneration	☐	☐
High blood pressure	☐	☐
Past heart attack	☐	☐
Past stroke	☐	☐
Blocked arteries	☐	☐
Heart failure	☐	☐
Mitral valve prolapse	☐	☐
Past heart bypass surgery	☐	☐
Have pacemaker	☐	☐
Past angioplasty	☐	☐
Obstructive sleep apnea	☐	☐
Asthma	☐	☐
COPD/Emphysema	☐	☐
Tuberculosis	☐	☐
Pneumonia	☐	☐
Use oxygen at home	☐	☐

	YES	NO
Reflux	☐	☐
Hiatal hernia	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Fibromyalgia	☐	☐
Gout	☐	☐
Multiple Sclerosis	☐	☐
Sarcoid	☐	☐
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Arthritis	☐	☐
Seizure disorder	☐	☐
Parkinson's disease	☐	☐
Spinal injury	☐	☐
Head injury	☐	☐
Meningitis	☐	☐

	YES	NO
Anxiety	☐	☐
Depression	☐	☐
Bipolar	☐	☐
HIV positive	☐	☐
Viral Load:_____ CD4 count:_____		
Low thyroid	☐	☐
Overactive thyroid	☐	☐
Thyroid nodule	☐	☐
Thyroid cancer	☐	☐
Diabetes – diet control	☐	☐
Diabetes – oral meds	☐	☐
Diabetes – insulin	☐	☐
Bleeding disorder	☐	☐

Other Significant Illness: (please specify):

_____
_____
_____
_____
_____
_____
_____

Do you have any history of cancer? _____YES_____NO

SITE:_____ TREATMENT:_____
SITE:_____ TREATMENT:_____
SITE:_____ TREATMENT:_____
SITE:_____ TREATMENT:_____

VACCINATIONS:

Have you had a **pneumonia vaccination?** ☐ YES ☐ NO DATE: _____
Have you had a **flu vaccination (within 12 months)?** ☐ YES ☐ NO DATE: _____
Have you had a **meningitis vaccination?** ☐ YES ☐ NO DATE: _____
Have you had a **hepatitis vaccination?** ☐ YES ☐ NO DATE: _____
Have you had an **HPV vaccination?** ☐ YES ☐ NO DATE: _____
Have you had a **herpes zoster vaccination?** ☐ YES ☐ NO DATE: _____

If you selected any of the above ↑, please explain.
Please tell us anything else we should know about your medical history.

_____
_____
_____
_____
_____
_____
_____

Name: _____ DOB: _____ Date: _____

SURGICAL HISTORY: Please mark <u>ALL</u> prior surgical procedures you have had:

☐ I HAVE HAD NO OPERATIONS/SURGERICAL PROCEDURES

NEUROSURGERY:

☐Anterior Cervical Fusion ☐Posterior Cervical Fusion ☐Lumbar Laminectomy

EYE:

☐Cataract Surgery ☐Glaucoma Surgery ☐Tear Duct Surgery

EAR, NOSE & THROAT:

☐PE Tubes
☐Middle Ear Surgery
☐External Ear Surgery
☐Tonsillectomy
☐Adenoidectomy
☐Septoplasty
☐Turbinate Reduction
☐Sinus Surgery
☐Rhinoplasty
☐Sleep Apnea
☐Vocal Cord Surgery
☐Airway Surgery
☐Thyroid Surgery
☐Parotid Surgery
☐Neck Surgery
☐Mastoidectomy
☐Tympanoplasty

ORAL:

☐TMJ
☐Recent Dental Work

CARDIOVASCULAR:

☐CABG
☐Angioplasty
☐Pacemaker
☐Implanted Defibrillator
☐Heart Valve Repair
☐Heart Valve Replacement
☐Surgery for Heart Defect
☐Aortic Aneurysm Repair
☐Lung Cancer Surgery
☐Bronchoscopy
☐Surgery for Airway Obstruction
☐Carotid Endartectomy
☐Balloon Angioplasty on Legs
☐Vascular Bypass Surgery on Legs

OTHER:

☐Breast Cancer Surgery ☐Hiatal Hernia ☐Hysterectomy

☐OTHER SURGERY: _____

ALLERGIES: Please mark all allergies you have or have had in the past.

☐I HAVE NO KNOWN ALLERGIES

☐Adhesive Tape ☐Food Allergy ☐Latex Allergy
☐Contact Allergy ☐Inhalant Allergy ☐Previous Skin Tests

Please list all FOOD, CONTACT, INHALANT and MEDICATION allergies. Include any prior skin test results.

ALLERGY:	REACTION:

MEDICATIONS: ☐ **I Consent to ALL Electronic Prescription Transactions**

Please mark all medications you take:

☐Use Aspirin ☐Use Plavix ☐Use Pradaxa

☐Use Coumadin ☐Use Non-Steroidal (such as Ibuprofen, Aleve) ☐Use other Blood Thinner _____

Please list ALL Medications you TAKE:

Include all prescription medications, vitamins, supplements & herbals.

MEDICATION:	DOSAGE & FREQUENCY:

Pharmacy Name and Phone Number: _____

Family History:

Please check those illnesses that are present in your immediate blood relatives (parents, children, siblings):

☐ Family History Unknown/Adopted
☐ Heart attack/heart disease
☐ Blocked arteries
☐ Past Stroke
☐ Allergies
☐ High Blood Pressure
☐ Diabetes
☐ Thyroid problems
☐ Cancer
☐ Hearing Loss
☐ Sickle cell/trait
☐ Bleeding problem
☐ Asthma
☐ NONE
☐ Other Significant Illness: _____

Social History:

What type of work/school do you do? _____

Who lives with you at home? _____

☐Live Alone
☐With Spouse/Partner
☐With Parents
☐With Children
☐With Other Family Member(s)
☐With Friend(s)
☐Shelter
☐In an Assisted Living Facility
☐With a Dog
☐With a Cat
☐Other: _____

Do you smoke?

☐ Yes, _____packs of cigarettes per day
☐ Quit _____years ago, smoked _____packs per day
☐ Never

Are you exposed to second hand smoke? ☐ YES ☐ NO

You consume _____alcoholic beverages per day/week/month (circle).

You consume _____caffeine beverages per day (coffee, tea, iced tea, soda, etc.).

You consume _____glasses of water per day.

Is there any chance you may be pregnant? ☐ YES ☐ NO ☐ N/A

Height: _____ Weight: _____

_____ Date: _____

Patient signature (Guardian if patient is a minor)

Reviewed by: _____