NAME _____
DATE _____
REFERRING DOCTOR_____
FAMILY DOCTOR_____
PREFERRED HOSPITAL_____
REASON FOR VISIT_____
_____
_____

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DO YOU HAVE OR HAVE YOU HAD DIFFICULTY WITH THE FOLLOWING:

NOSE:

NOSE BLEEDS	_____YES _____NO
BREATHING OUT OF THE NOSE	_____YES _____NO
STUFFINESS IN THE NOSE	_____YES _____NO
SINUS CONGESTION	_____YES _____NO
SINUS PRESSURE	_____YES _____NO
HEADACHE IN THE SINUES AREA	_____YES _____NO
POST NASAL DRAINAGE	_____YES _____NO
DISTURBANCE/LOSS OF SMELL	_____YES _____NO
LONG TERM USE OF NASAL SPRAYS	_____YES _____NO

THROAT:

HOARSENESS	_____YES _____NO
THROAT INFECTIONS	_____YES _____NO
SORE THROATS	_____YES _____NO
CHRONIC COUGH	_____YES _____NO
DIFFICULTY SWALLOWING	_____YES _____NO
DO YOU SMOKE	_____YES _____NO
HOW MUCH _____ HOW OFTEN_____	
IS THERE HOUSEHOLD SMOKE	_____YES _____NO
ACID REFLUX	_____YES _____NO
DO YOU DRINK ALCOHOL	_____YES _____NO
HOW MUCH_____HOW OFTEN_____	
SLEEP DISTURBANCE	_____YES _____NO
SNORING	_____YES _____NO
ANXIETY/PANIC ATTACKS	_____YES _____NO

EARS:

EAR INFECTIONS	_____YES _____NO
DIZZINESS/VERTIGO	_____YES _____NO
RINGING/BUZZING SOUNDS	_____YES _____NO
PAIN	_____YES _____NO
PRESSURE	_____YES _____NO
ITCHING	_____YES _____NO
POPPING	_____YES _____NO
SWELLING	_____YES _____NO
BLEEDING/DISCHARGE	_____YES _____NO
HISTORY OF INJURY	_____YES _____NO
HEARING PROBLEMS	_____YES _____NO
WHICH EAR IS WORSE ___R ___L	
HEARING AID USAGE	_____YES _____NO

PATIENT SIGNATURE _____

PHYSICIAN SIGNATURE_____

GENERAL HEALTH:

ASTHMA	_____YES _____NO
SEASONAL ALLERGIES	_____YES _____NO
ARTHRITIS	_____YES _____NO
HIGH CHOLESTEROL	_____YES _____NO
HEARTBURN/INDIGESTION	_____YES _____NO
HIGH BLOOD PRESSURE	_____YES _____NO
THYROID TROUBLE	_____YES _____NO
HEART TROUBLE	_____YES _____NO
PACEMAKER	_____YES _____NO
CHEST PAIN	_____YES _____NO
STROKE	_____YES _____NO
HEART ATTACK	_____YES _____NO
ANEMIA	_____YES _____NO
BLEEDING ABNORMALITIES	_____YES _____NO
DIABETES	_____YES _____NO
TYPE _____	
HEPATITIS	_____YES _____NO
HIV/AIDS	_____YES _____NO
ARE YOU PREGNANT	_____YES _____NO
DUE DATE_____	
CLAUSTRAPHOBIC	_____YES _____NO
ANY METAL IN EYES	_____YES _____NO
GLAUCOMA	_____YES _____NO

FAMILY HISTORY:

FATHER ALIVE_____ DECEASED _____
CAUSE OF DEATH_____
MOTHER ALIVE_____ DECEASED _____
CAUSE OF DEATH_____

NUMBER OF SIBLINGS:
ALIVE_____ DECEASED_____

MEDICATION ALLERGIES _____ YES _____ NO
PLEASE LIST:_____
_____

REACTION TO ANESTHESIA? _____YES _____NO

LIST ANY HOSPITALIZATIONS AND SURGERIES:
_____
_____
_____
_____

ANY OTHER MEDICAL CONDITIONS:_____
_____
_____
_____