Pocatello Ear, Nose and Throat

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Today's Date:_____

Patient Name: _____ Age: _____ Date of Birth: _____

What are you being seen for today? _____

When did symptoms begin? _____What treatments have you tried? _____

_____

Medical History_____

_____

ALL PREVIOUS SURGERY: _____

_____

PLEASE LIST ALL YOUR CURRENT MEDICATIONS, PRESCRIPTION, HERBAL, AND OVER THE COUNTER

Prescription Medications	Dose	Medications continued	Dose	Herbs/Vitamins/OTC	Dose

_____

Medication Allergies: ☐**YES** ☐ **NO** If yes, please list._____

Latex Allergy: ☐ **YES** ☐**NO**

Are you pregnant? ☐ **YES** ☐ **NO** How many weeks? _____

Occupation: _____

Day Care Attendance: ☐**YES** ☐**NO** _____Days per week.

Are you current on Flu vaccine ≥**2 years**? ☐**YES** ☐**NO**

Are you current on Pneumococcal Pneumonia vaccine **≥55 years**? ☐**YES** ☐**NO**

Currently smoke or chew Tobacco? ☐**YES** ☐**NO**

How many ☐packs ☐cans per day? _____ How many years? _____

Are you a former smoker? ☐**YES** ☐**NO** How long? _____

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

Is there smoking in your home? ☐**YES** ☐ **NO**

Do you consume Alcohol? ☐**YES** ☐**NO**

How many drinks per ☐day ☐week do you consume? _____

Recreational Drug use: ☐**YES** ☐**NO** If yes please list: _____

FAMILY HISTORY:

Diabetes ☐Self ☐Mother ☐Father ☐Sibling

Heart Disease ☐Self ☐Mother ☐Father ☐Sibling

Thyroid Disease ☐Self ☐Mother ☐Father ☐Sibling

Cancer ☐Self ☐Mother ☐Father ☐Sibling

High Blood Pressure ☐Self ☐Mother ☐Father ☐Sibling

Malignant Hyperthermia ☐Self ☐ Mother ☐Father ☐Sibling

Anesthesia Complications ☐Self ☐Mother ☐Father ☐Sibling

Hearing loss ☐Self ☐Mother ☐Father ☐Sibling

Allergies/Hayfever ☐Self ☐Mother ☐Father ☐Sibling

Asthma ☐Self ☐Mother ☐Father ☐Sibling

Migraines ☐Self ☐Mother ☐Father ☐Sibling

High Cholesterol ☐Self ☐Mother ☐Father ☐Sibling

Autoimmune disease ☐Self ☐Mother ☐Father ☐Sibling

Bleeding problems ☐Self ☐Mother ☐Father ☐Sibling

***Please list specific autoimmune disorder:** _____

PLEASE CHECK BELOW, PAST OR PRESENT SYMPTOMS:

NOSE

- ☐ Bleeding
- ☐ Previous Cautery
- ☐ Plugged/blocked
- ☐ Sneezing
- ☐ Trauma
- ☐ Discharge
- ☐ Mouth Breathing
- ☐ Poor sense of smell

DIZZINESS

- ☐ Unsteadiness
- ☐ Spinning/Whirling
- ☐ Direction Left/Right
- ☐ Floating
- ☐ Position Related
- ☐ Nausea/Vomiting
- ☐ Falls
- ☐ Stroke
- ☐ Blackouts

ALLERGIES

- ☐ Clear Drainage
- ☐ Sneezing
- ☐ Nasal Stuffiness
- ☐ Headaches
- ☐ Itchy/watery eyes
- ☐ Rash/Hives
- ☐ Seasonal or Always
- ☐ Pets in home
- ☐ Allergy Testing

Headaches

- ☐ Location _____
- ☐ Warning signs
- ☐ Nausea/vomiting
- ☐ Stress/Migraine
- ☐ Frequency _____
- ☐ Duration _____

THROAT/ACID REFLUX

- ☐ Sore Throat
- ☐ Cough
- ☐ Lump/Mass
- ☐ Post Nasal Drip
- ☐ Heart burn/Indigestion
- ☐ Acid taste in throat
- ☐ Frequent throat clearing
- ☐ Hoarseness

OTHER

- ☐ Shortness of breath
- ☐ Facial pain/pressure
- ☐ Fatigue
- ☐ Teeth grinding
- ☐ Jaw pain
- ☐ Weight Loss/Gain
- ☐ Chest pain
- ☐ Palpitations
- ☐ Dialysis
- ☐ Renal Failure **STAGE:**_____
- ☐ Problems Urinating
- ☐ Bruise easily