LONG ISLAND ENT

NAME: _____ **ACCOUNT #** _____ (filled in by office)

My Chief Complaint (why I'm being seen today) is: _____

Review of Systems – please circle whether you presently have the following symptoms:

General: Fever. Chills. Headaches.
Eyes: Blurred vision. Glaucoma.
Ears: Hearing loss. Ear pain. Ringing in the ears. Dizziness. Vertigo. Drainage. Hearing aides. Chronic noise exposure in the past. Chronic noise currently. Clogged ears.
Nose: Bleeding. Difficulty breathing. Stuffiness. Postnasal drip. Nasal sprays. Snoring. Nasal surgery. Hay fever/allergies. Injuries to nose. Broken nose. Sinus pain. Sinus pressure.
Throat: Soreness. Pain/difficult swallowing. Voice changes. Hoarse. Bad: Taste/breath. Throat clearing.
Neck: Lump. Thyroid nodules. Pain. Swollen glands.
Respiratory: Shortness of breath. Cough. Wheezing. Asthma. Bronchitis.
GI: Reflux. Heartburn. Nausea. Ulcers. Vomiting. Diarrhea.
Endocrine: Diabetes. Weight loss or gain. Fatigue. Pregnancy. Thyroid problem.
Blood/Lymphatics: Easy bleeding or bruising. Anemia. Swollen glands.
Skin: Unexplained rash. Psoriasis. Skin cancers. Eczema.
Cardiovascular: Chest pain. Angina. Palpitations.
Neurologic/Psych: Stroke. Weakness. Anxiety. Depression.
Musculoskeletal: TMJ problems. Grinding teeth. Neck arthritis/stiffness.

PAST MEDICAL HISTORY:
Circle if you have had the following illnesses.
Use the line to write a description if you like.

Allergies (example hayfever)_____
Anemia (low iron)
Anxiety _____
Arthritis _____
Back pain _____
Cancer skin lesions _____
Non-cancer skin lesions_____
Depression_____
Diabetes
Dizziness _____
Ear infections_____
Eye problems _____
Headaches_____
Hearing loss _____
Heart disease_____
Hepatitis_____
High cholesterol
High triglycerides
Hypertension (high blood pressure)
Immune deficiency_____
Kidney problem_____
Lung problems_____
Nose bleeds
Panic disorder_____
Skin problem_____
Stomach problem_____
Thyroid Disorder_____

Were you ever tested tuberculosis positive (Positive PPD?) _____
Other medical history _____

MY ALLERGIES TO MEDS _____
MY CURRENT MEDS _____

Please circle or write in the correct choices for all categories below

Please circle if brother/sister, child, or close relative has:

Anesthesia complication. Bleeding disorder. Cancer. Diabetes. Hearing Loss. Heart disease. High blo pressure. Thyroid disease. Important other: _____

SOCIAL HISTORY:

I am: Single. Married. Divorced. Widowed. Student.
Smoking: Never smoked. Smoke _____ pack per day. I used to smoke but quit _____ (how long ago). I smoke cigars.
Alcohol: No alcohol. Beer. Wine. Hard liquor. Use approximately _____ servings of alcohol per week. Rare use of alcohol. Light use of alcohol. Moderate use of alcohol. Heavy use of alcohol.
Drugs: Have never used illicit drugs. Used _____ drug previously. Occasionally use the drug _____ now.
Caffeine: None. Per day: 1 serving. _____ servings.
Diet: My diet is: Regular. Diabetic. Heart healthy. High cholesterol. Soft.

HOSPITALIZATIONS:

None. I was hospitalized for the surgeries circled in the next section below.
I was hospitalized for routine childbirth.
Hospitalized in _____ for _____. Also hospitalized in _____ for _____

OPERATIONS/SURGERY:

I have had no previous surgery.

Surgery: _____ (when) _____

Surgery: _____ (when) _____

Surgery: _____ (when) _____