THE ENT CENTER OF CENTRAL GA

Patient Name _____

Pharmacy Name _____ **Pharmacy Location** _____

Medical Record # _____

MEDICATIONS List of Current Medications *including Strength & Dosage*:

1._____ **7.**_____

2._____ **8.**_____

3._____ **9.**_____

4._____ **10.**_____

5._____ **11.**_____

6._____ **12.**_____

ALLERGIES List Any Medications You Are Allergic To:

1._____ **Reaction:** _____

2. _____ **Reaction:** _____

3._____ **Reaction:** _____

REVIEW OF SYSTEMS
Please circle if you are <u>CURRENTLY</u> experiencing any of the following symptoms:

Constitutional
Weight loss
Fatigue
Fever
Irritability
Weight Gain
Insomnia

Respiratory
Cough
Shortness of breath
Spitting/Coughing up blood
Snoring
Wheezing

Cardiovascular
Shortness of breath at night
Irregular heartbeat/palpitations

Neurologic
Headache
Anxiety
Depression
Seizures

Eyes
Dry eyes
Watery eyes
Itchy eyes
Light sensitivity
Redness

Ears
Discharge
Excess wax
Fullness
Hearing loss
Ear pain
Ringing of ears
Dizziness

Nose/Sinus
Discharge
Nosebleed
Facial Pain
Congestion
Nasal blockage
Sneezing

Throat/Mouth
Sore tongue
Voice change
Lump in throat
Problems swallowing
Post nasal drainage
Hoarseness

Gastrointestinal
Nausea
Acid reflux
Vomiting
Heartburn

Immunological
Animals in the home
Environmental allergies
Eczema
Hay Fever
Asthma
Food allergies

Metabolic/Endocrine
Cold intolerance
Heat intolerance
Overweight
Underweight

Hematologic
Easy bruising
History of blood clots
Easy bleeding

PAST MEDICAL HISTORY

Please circle if you have a HISTORY of any of the following:

Heart disease	Anemia	Lupus	COPD
Stroke	Bleeding disorder	Fibromyalgia	Emphysema
Congestive Heart Failure	Allergies	Depression	Asthma
Hypertension	HIV	Anxiety	Cancer _____
High Cholesterol	Hepatitis _____	Seizures	Thyroid problems
Acid Reflux	Diabetes	Migraines	Sleep Apnea
Dizziness	Kidney Disease		CPAP use? Yes No

PAST SURGICAL HISTORY: Please list ALL past surgeries and approximate year

1._____ 4._____ 7._____

2. _____ 5._____ 8._____

3._____ 6._____ 9._____

FAMILY HISTORY: Please indicate which family member is affected (mother, father, maternal/paternal grandparents, sister, brother)

Allergies_____ Diabetes_____ Kidney Disease_____

Asthma_____ Childhood Hearing Loss_____ Seizures_____

Bleeding Disorder_____ Cancer_____What type _____ Sickle Cell_____

Heart Disease_____ Migraines_____ Thyroid Disorder_____

Hypertension_____ Stroke_____ Sleep Apnea _____

TOBACCO USE: Yes Never Former

If yes, how much per day?_____ How old were you when you started?_____

If former, how old were you when you quit?_____

ALCOHOL USE: Yes No

If yes, what type? _____ How often? Daily Weekly Occasionally Socially Rarely

CAFFEINE USE: Coffee Tea Soft Drinks Energy Drinks

SOCIAL HISTORY:

Married, Single, Divorced, Widowed_____ Do You Have Children? Yes No

Occupation:_____ Pets in the Home: _____

Military Experience: Yes No Highest Level of Education: _____

Noise exposure (work environment, hunting, etc.) _____ Would you accept a blood transfusion? Yes No

IF PATIENT IS AGE 17 OR UNDER, PLEASE ANSWER THE FOLLOWING:

Who lives in the home with the patient? _____

Was patient full-term at birth? Yes No If no, at what week were they born? _____ Pass newborn hearing screen? Yes No

NICU stay? Yes No Ventilator? Yes No Circumcision? Yes No Does anyone smoke at home? Yes No Inside Outside