

GREENSBORO EAR, NOSE & THROAT ASSOCIATES, P.A.

NAME: _____ AGE: _____ DATE: _____

YOUR REGULAR DOCTOR _____

WHO SENT YOU HERE? _____ MARITAL STATUS: _____

1. What symptoms brought you here? _____

2. How long has this been bothering you? _____ (hrs, days, months, years, etc.)

	Yes	No	How much/What kind/When quit?
3. Alcohol consumption?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Do you smoke now?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Do you chew tobacco/use snuff?	<input type="checkbox"/>	<input type="checkbox"/>	_____

7. Has your weight changed during the past year? Gained _____ Lost _____ No _____

If yes, how many pounds did you lose/gain? _____

8. Please list any operations that you have had (such as tonsillectomy, appendectomy, hernia repair, gallbladder, etc.) and the approximate year.

<u>Operation</u>	<u>Date</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

9. Please list any medications (including aspirin, birth control pills, etc.)

<u>Name of Medicine</u>	<u>How much each day?</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

10. Are you allergic to any medications (aspirin, penicillin, etc.)?

<u>Name of Medicine</u>	<u>Reaction</u>
1. _____	_____
2. _____	_____

Please turn over and complete reverse side.

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11. Have you or anyone in your immediate family had any of these problems?

	NO	YES	IF YES, EXPLAIN (yourself or relative e.g. mother, son, uncle)
Asthma/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional/Mental	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indigestion/Heart Burn	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Fevers	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sugar Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Syphilis/Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

12. Have you had any recent symptoms related to the following body systems?

- General (e.g. general health, fever, chills, sweats) _____
- Eyes (e.g. vision changes, double vision, blurry vision) _____
- Cardiovascular (e.g. chest pain, palpitations, fainting) _____
- Respiratory (e.g. shortness of breath, cough, pneumonia) _____
- Gastrointestinal (e.g. nausea, vomiting, swallowing problems) _____
- Genitourinary (e.g. kidney stones, pain with urination) _____
- Musculoskeletal (e.g. joint pain, muscle weakness, swelling) _____
- Skin (e.g. rash, skin lesion, sores, bruising) _____
- Neurological (e.g. weakness, numbness) _____
- Psychiatric (e.g. depression, anxiety) _____
- Endocrine (e.g. dry skin, cold or heat intolerance) _____