

ENT

CLINIC OF PUEBLO, P.C.

Patient Name _____

Date of Birth _____

CURRENT MEDICAL CONDITION

What medical problems are you experiencing? Describe your symptoms. _____

Date of Onset of Condition _____

LIST ALL PREVIOUS SURGERIES

PERSONAL MEDICAL HISTORY

Have you ever had, or do you every have any of the following? *(Check all boxes that apply)*

- High Blood Pressure
- Thyroid Problems
- High Blood Pressure
- Stroke
- Heart Problems/CHF
- Heart Murmur
- Sinus Surgery
- Septoplasty
- Cancer, Explain
- Arthritis
- Lupus
- Anemia
- HIV or AIDS
- Bleeding Disorders
- Blood Clots
- Bronchitis
- Tonsillectomy
- Other _____
- Emphysema
- Asthma
- Hay Fever
- Migraines
- Epilepsy or Seizures
- Meningitis
- Serious Head Injury
- Blood Transfusion Restrictions
- Dentures/Partials
- Hiatal Hernia
- Indigestion
- Vertigo
- Hearing Loss
- Sleep Apnea
- Use CPAP

ALLERGIES

Have you ever had, or do you every have any of the following? *(Check all boxes that apply)*

- Allergies to latex products such as exam gloves or balloons
- Allergies to medications? If so, please list _____

MEDICATIONS

Please list all the medications that you are currently taking *(including over the counter and herbal medications)*

Medication	Dosage	How Often

SOCIAL HISTORY

Weight _____ Height _____

Do you currently smoke or did you ever smoke? Yes No If yes, Packs/Day _____ Years _____

Do you chew tobacco or smoke a pipe or cigar? Yes No If yes, how much per day? _____ Years _____

If no longer smoking or chewing when did you quit? _____

How many drinks of alcohol do you have in a typical week? _____

How much caffeine do you have in a typical day (include coffee, tea & pop)? _____

How much water do you drink in a typical day? _____

Do you use recreational or street drugs? Yes No If yes, how often? _____

Highest Level of Education: High School Some College College Graduate

Occupation _____


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FAMILY MEDICAL HISTORY*Please check all the diseases that run in your family*

Disease	Mother	Father	Grandparent	Sibling	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory or Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia Reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Significant Disease					

REVIEW OF SYMPTOMS*Please check symptoms you currently have.***GENERAL:** Fever Chills Night Sweats Fatigue Unexplained Weight Loss or Gain**EYES:** Wear glasses or contacts Cataracts Glaucoma Vision Loss Blurry Vision
 Double Vision**EARS:** Hearing Aids Hearing Loss Exposure to Loud Sounds Ringing in Ears
 Dizziness or Balance Problems Pain or Drainage**NOSE AND SINUS:** Nasal Congestion Nose Bleeds Frequent Sinus Infections Post Nasal Drip
 Hay Fever Allergies**SPEAKING AND SWALLOWING:** Difficulty Chewing or Swallowing Problems Speaking Hoarseness
 Mouth or Throat Pain Sores in Mouth or on Tongue**ENDOCRINE:** Thyroid Problems Excessive Sweating Cold Intolerance Tremor**RESPIRATORY:** Use Oxygen Shortness of Breath Chronic Cough Wheezing**CARDIAC:** Chest Pain Enlarged Heart Heart Failure Irregular Heartbeat Heart Murmur
 Pacemaker**GASTROINTESTINAL:** Bleeding Ulcers Hiatal Hernia Reflux Frequent Heartburn**NEUROLOGICAL:** Migraines Frequent Headaches Seizures Dizziness Bells' Palsy**BLOOD:** Anemia Bleeding Problems Easy Bruising Blood Clots Swollen Glands**SKIN:** Rashes Non-Healing Sores Infections Skin Lesions