Central Carolina ENT Associates PA Chart # _____

Patient History Information

Name: Date:

Pharmacy Pharmacy address City:

What is the reason for your visit today?

How long has the present problem been?

What treatments have you had?

Please list any allergies to medications:

Please list all medications, including aspirin, over the counter medications, birth control:

Past Medical History: Have you ever been treated for the following medical conditions **IN THE PAST**? **Check yes or no and then circle all that apply.** You may add additional information if necessary.

☐ Yes ☐ No CV Hx: angina, arrhythmia, cath, cardiac disease, heart failure, murmur, heart attack, pacemaker
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Skin Diseases (eczema, psoriasis, acne)
☐ Yes ☐ No Endocrine Hx: Diabetes, Thyroid Disease (hypo, hyper, Graves Disease)
☐ Yes ☐ No Gastrointestinal Disease (reflux, ulcers, intestinal, hepatitis, cirrhosis)
☐ Yes ☐ No Genito-urinary Disease (dialysis, kidney stones)
☐ Yes ☐ No HEENT: Allergies (seasonal), cholesteatoma, Meniere's
☐ Yes ☐ No Heme: Blood Diseases (anemia, bleeding problems)
☐ Yes ☐ No Imm: Cancer (list type or location & date) Chemo Radiation
☐ Yes ☐ No Infections (TB, syphilis, HIV)
☐ Yes ☐ No Musculoskeletal: Arthritis (rheumatoid, osteo-degenerative), fibromyalgia, TMJ
☐ Yes ☐ No Neurological problems (strokes, seizures, headache, vertigo)
☐ Yes ☐ No Mental Health (depression, anxiety, bipolar)
☐ Yes ☐ No Respiratory Disease (asthma, bronchitis, COPD, emphysema, pneumonia, sleep apnea)
☐ Yes ☐ No use CPAP
☐ Yes ☐ No Other problems:

Previous Surgery (date/type)

Previous ENT Surgery/Date (tonsils, ear tubes, throat, neck or sinus surgery, etc.)

Social History:

Do you smoke tobacco? ☐ Yes ☐ No If yes, ___packs per day x ___years.
Have you ever smoked? ☐ Yes ☐ No If yes, ___packs per day x ___years. Quit ___y ago
Do you smoke cigars? ☐ Yes ☐ No Quit ___y ago
Do you chew tobacco? ☐ Yes ☐ No Quit ___y ago
Do you drink alcohol? ☐ Yes ☐ No If yes, occasional, moderate or heavy. Quit___y ago
Other drug use
Are you pregnant? ☐ Yes ☐ No Breast Feeding? ☐ Yes ☐ No LMP_____

Central Carolina ENT Associates PA Chart # _____

SEE OTHER SIDE

Family History: Do you have a family history of disease? Please list the relative.

☐ Yes ☐ No Allergies_____
☐ Yes ☐ No Anesthesia problems_____
☐ Yes ☐ No Bleeding Disorder_____
☐ Yes ☐ No Cancer_____
☐ Yes ☐ No Diabetes_____
☐ Yes ☐ No Hearing Loss_____
☐ Yes ☐ No Heart Disease: heart attack_____Hypertension_____

Review of Systems: Do you <u>CURRENTLY</u> have any of the following problems? Check yes or no then circle all that apply:

☐ Yes ☐ No HEENT: bloody nasal discharge, burning sensation in mouth, change in voice, cough, difficulty hearing, difficulty swallowing, ear drainage, ear infection, ear pain, facial fractures, facial swelling, jaw pain, loss of sense of smell or taste, lumps in mouth and neck, mouth bleeding, post-nasal drip, ringing in ears, runny nose, sinus problems, sore throat
☐ Yes ☐ No Allergies: animals, seasonal, itchy eyes, itchy nose, sneezing
☐ Yes ☐ No Respiratory: asthma, difficulty breathing, daytime sleepiness, coughing up blood, difficulty sleeping, shortness of breath, sleep apnea, snoring, wheezing
☐ Yes ☐ No CV: chest pain, edema, elevated BP, heart attack, heart palpitation, irregular heartbeat, pacemaker, shortness of breath with exercise
☐ Yes ☐ No Constitutional: fever, night sweats, tiredness, weight loss
☐ Yes ☐ No Endocrine: high/low blood sugar, thyroid disease
☐ Yes ☐ No Eye problems: abrupt visual loss, dry eyes, itchy eyes, excess tearing, swelling around eyes, red eyes, visual disturbance, double vision
☐ Yes ☐ No GI: abdominal pain, diarrhea, difficulty swallowing, heartburn
☐ Yes ☐ No GU: blood in urine, painful urination
☐ Yes ☐ No Musculoskeletal: Joint Pain
☐ Yes ☐ No Neuro: balance problems, headache, migraines, seizures, stroke, vertigo
☐ Yes ☐ No Mental Health: anxious feelings, depression
☐ Yes ☐ No Derm: dry scaly skin, facial rash, hypertrophic scars, non-healing wound
☐ Yes ☐ No Heme: anemia, bleeding problems, bruise easily, clots in vein or lungs
☐ Yes ☐ No Cosmetic Concerns: facial skin care, Botox, Restylane, other procedures

_____ _____
Signature Relationship to Patient

4/27/09