Welcome to ENT of Georgia. Our goal is to provide you and your family with the highest of care. The first step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete all pages of the form below. Our staff would be glad to help you if necessary. The care we give you can be no better than the information you provide.

Name: _____ Age: _____ Date of Birth: _____
First MI Last MM/DD/YYYY

Who sent you to us today? _____

This person is: ☐ Primary Physician
☐ Other Physician
☐ Non-physician health care provided
☐ Friend/Other

Gender: ☐ Male ☐ Female

**Primary physician** (name and phone number)
_____
_____

**Please name the major problem or symptom that brings you to us today:**

_____

_____

**Please describe the history of your present illness in detail:**

_____

_____

_____

_____

_____

Rate the severity of **today's** symptoms on a 1 – 10 scale (10 = worst): _____

How long have your symptoms been present? _____

What makes your symptoms worse or better? _____

What other providers have you seen for this illness? _____

What diagnostic tests have been performed so far? _____

_____

What treatments have been tried so far (include operations done for this illness)?

_____

_____

Please check YES for those symptom below which apply to **YOU,** or NO for those symptoms that do not apply:

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Severe headache | ☐ | ☐ | Nasal obstruction | ☐ | ☐ | Difficulty swallowing | ☐ | ☐ |
| Failing vision | ☐ | ☐ | Nosebleed | ☐ | ☐ | Can't clear throat | ☐ | ☐ |
| Eye pain | ☐ | ☐ | Loss of smell/taste | ☐ | ☐ | Cough | ☐ | ☐ |
| Double vision | ☐ | ☐ | Hearing loss | ☐ | ☐ | Hoarseness | ☐ | ☐ |
| Nasal congestion | ☐ | ☐ | Ringing in ears | ☐ | ☐ | Heartburn | ☐ | ☐ |
| Facial pain | ☐ | ☐ | Ear pain | ☐ | ☐ | Neck mass/swollen glands | ☐ | ☐ |
| Nasal discharge | ☐ | ☐ | Ear drainage | ☐ | ☐ | Snoring | ☐ | ☐ |
| Post-nasal drip | ☐ | ☐ | Dizzy/off balance | ☐ | ☐ | Stop breathing during sleep | ☐ | ☐ |
| Frequent sneezing | ☐ | ☐ | Ear fullness/pressure | ☐ | ☐ | Sleepy in the daytime | ☐ | ☐ |

Reviewed by: _____

## Review of Systems:

Please check YES for those symptoms below which apply to **YOU,** and NO for those symptoms that do not apply.

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Fever/Chills | ☐ | ☐ | Abdominal pain | ☐ | ☐ | Weakness | ☐ | ☐ |
| Weight loss | ☐ | ☐ | Nausea/vomiting | ☐ | ☐ | Shaking/tremor | ☐ | ☐ |
| Night sweats | ☐ | ☐ | Yellow jaundice | ☐ | ☐ | Fainting | ☐ | ☐ |
| | | | Bloody/black stool | ☐ | ☐ | | | |
| Light bothers eyes | ☐ | ☐ | Diarrhea | ☐ | ☐ | High stress | ☐ | ☐ |
| Irritated eyes | ☐ | ☐ | | | | Depression | ☐ | ☐ |
| Eyes crust/drain | ☐ | ☐ | Painful urination | ☐ | ☐ | Mood swings | ☐ | ☐ |
| | | | Weak urine stream | ☐ | ☐ | | | |
| Chest pain | ☐ | ☐ | Blood in urine | ☐ | ☐ | Cold intolerance | ☐ | ☐ |
| Irregular heartbeat | ☐ | ☐ | | | | Heat intolerance | ☐ | ☐ |
| | | | Painful/swollen joints | ☐ | ☐ | Frequent thirst | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ | Back pain | ☐ | ☐ | | | |
| Wheezing | ☐ | ☐ | | | | Anemia | ☐ | ☐ |
| Cough up blood | ☐ | ☐ | Rash | ☐ | ☐ | Bruise easily | ☐ | ☐ |
| | | | Hair/nail problems | ☐ | ☐ | Prolonged bleeding | ☐ | ☐ |
| | | | Flaking/peeling skin | ☐ | ☐ | | | |
| | | | Itchy skin | ☐ | ☐ | HIV Risk Factors | ☐ | ☐ |

## Past Medical History

Please check YES for those illnesses you **have** or **have had in the past.** Check NO for those illnesses you **have never had:**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Glaucoma | ☐ | ☐ | Reflux | ☐ | ☐ | Low thyroid | ☐ | ☐ |
| Cataract | ☐ | ☐ | Hiatal hernia | ☐ | ☐ | Overactive thyroid | ☐ | ☐ |
| Macular degeneration | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Thyroid nodule | ☐ | ☐ |
| | | | Hepatitis B | ☐ | ☐ | Thyroid cancer | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | Hepatitis C | ☐ | ☐ | Diabetes – diet control | ☐ | ☐ |
| Past heart attack | ☐ | ☐ | | | | Diabetes – oral meds | ☐ | ☐ |
| Past stroke | ☐ | ☐ | Fibromyalgia | ☐ | ☐ | Diabetes - insulin | ☐ | ☐ |
| Blocked arteries | ☐ | ☐ | Gout | ☐ | ☐ | | | |
| Heart failure | ☐ | ☐ | Arthritis | ☐ | ☐ | Food allergy | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | | | | Contact allergy | ☐ | ☐ |
| Past bypass surgery | ☐ | ☐ | Seizure disorder | ☐ | ☐ | Latex allergy | ☐ | ☐ |
| Have pacemaker | ☐ | ☐ | Parkinson's disease | ☐ | ☐ | Adhesive tape allergy | ☐ | ☐ |
| Past angioplasty | ☐ | ☐ | Spinal injury | ☐ | ☐ | Inhalant allergy | ☐ | ☐ |
| | | | Head injury | ☐ | ☐ | Previous skin tests | ☐ | ☐ |
| Obstructive sleep apnea | ☐ | ☐ | Meningitis | ☐ | ☐ | | | |
| Asthma | ☐ | ☐ | | | | Bleeding disorder | ☐ | ☐ |
| COPD/Emphysema | ☐ | ☐ | Mental Health problems | ☐ | ☐ | Use aspirin | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | | | | Use Coumadin | ☐ | ☐ |
| Pneumonia | ☐ | ☐ | HIV positive | ☐ | ☐ | Use Plavix | ☐ | ☐ |
| Use oxygen at home | ☐ | ☐ | | | | Use non-steroidal (such as ibuprofen, Aleve) | ☐ | ☐ |
| | | | | | | Use other blood thinner | ☐ | ☐ |

Please list all food, contact and inhalant allergies.
Do **not** include drug allergies. Include any prior skin test results:

_____

_____

If you answered **YES** to any of the above, please explain. Please tell us anything else we should know about your medical history:

_____

_____

Do you have any history of cancer? _____ If yes, please list site(s) and treatment:

_____

_____

**Have you had a pneumonia vaccination?** ☐ YES ☐ NO DATE: _____

**Have you had a flu vaccination?** ☐ YES ☐ NO DATE: _____

Reviewed by: _____

Name: _____ DOB: _____ Date: _____

**Surgical History:**
**Please list ALL prior surgical procedures:**

| Operation: | Date: | Operation: | Date: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Medications you TAKE:**
Include vitamins, supplements & herbals
☐ **I Consent to ALL Electronic Prescription Transactions**

| Drug Name: | Dosage: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Medication/Food ALLERGY**
List allergies & bad reactions to medications/food
Latex Allergy ☐ YES ☐ NO

| Drug/Food Name: | Reaction: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Pharmacy Name and Phone Number:** _____

**Family History:**
**Please check those illnesses that are present in your immediate blood relatives (parents, children, siblings):**

| | | |
|---|---|---|
| ☐ Heart attack/heart disease | ☐ High Blood Pressure | ☐ Hearing Loss |
| ☐ Blocked arteries | ☐ Diabetes | ☐ Sickle cell/trait |
| ☐ Past Stroke | ☐ Thyroid problems | ☐ Bleeding problem |
| ☐ Allergies | ☐ Cancer | ☐ Asthma |

**Social History:**
What type of work/school do you do? _____

Who lives with you at home? _____

Do you smoke?

☐ Yes, _____packs of cigarettes per day
☐ Quit _____years ago, smoked _____packs per day
☐ Never

You consume _____alcoholic beverages per day/week/month (circle).

You consume _____caffeine beverages per day (coffee, tea, iced tea, soda, etc.).

You consume _____glasses of water per day.

Is there any chance you may be pregnant? ☐ YES ☐ NO ☐ N/A

Height: _____ Weight: _____

_____ Date: _____
**Patient signature (Guardian if patient is a minor)**