St. Joseph's
Ear, Nose, Throat & Allergy Clinic

Appointment Date: _____ Date of Birth: _____

Last Name: _____ First Name: _____

Pharmacy

Family Physician

Referring Physician

What is the reason for your visit today?

How long has this problem been going on?

Status:

- Acute
- Chronic
- Improving
- Worse
- No Change
- Asymptomatic

Frequency:

- Random
- Constant
- Daily
- Weekly
- Monthly

Severity:

- Incapacitating
- Mild
- Mild-Moderate
- Moderate
- Moderate-Severe
- Severe

Current medications including dosage: (Do you take Aspirin (Anti-Inflammatory), Coumadin (Anti-Coagulation), or Vitamin E? -please note below)

Do you have allergies to medications including reaction? Latex?

Current Health

Do you currently have any of the following medical problems?

- Chills
- Fatigue
- Fever
- Weight Loss
- Weight Gain
- Ear Drainage
- Ear Pain
- Eye Discharge
- Eye Pain
- Hearing Loss
- Nasal Drainage
- Sinus Pressure
- Sore Throat
- Visual Changes
- Cough
- Shortness of Breath
- Hemoptysis (Coughing Blood)
- Snoring
- Wheezing
- Chest Pain
- Palpitations
- Heartburn/Reflux
- Nausea
- Vomiting
- Hematuria (Blood in Urine)
- Urinary Retention
- Heat Intolerance
- Cold Intolerance
- Tremors
- Anxiety
- Depression
- Insomnia
- Hives
- Mole Changes
- Rash
- Skin Lesion
- Joint Swelling
- Muscle Weakness
- Neck Pain
- Easy Bleeding
- Easy Bruising
- Enlarged Lymph Nodes
-

Last Name: _____ First Name: _____

- ○ Hoarseness
- ○ Food Sticking
- ○ Visual Loss
- ○ Epistaxis (Nose Bleed)
- ○ Facial Pain
- ○ Other: _____
- ○ Dizziness
- ○ Gait Disturbance
- ○ Headache
- ○ Memory Loss
- ○ Seizures
- ○ Contact Allergy
- ○ Environmental Allergies
- ○ Food Allergies
- ○ Seasonal Allergies
- ○ Ringing/Tinnitus

Surgical History

☐ Never had surgery

☐ Any complications? Anesthesia complications?

Hospitalization History

☐ Never been hospitalized

	Procedure(s)/Hospitalizations	Year		Procedure(s)/Hospitalization(s)	Year
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		

<u>Past</u> Medical History and Family History *Please indicate only close (1st degree) relationships (i.e. mother, father, brother, sister) only. Are your parents alive or deceased? A__ D__ Mother A__ D__ Father

Self	Relative	Condition	Self	Relative	Condition	Self	Relative	Condition
○		Asthma	○		Heart Disease	○		Lupus
○		Anemia	○		Hypertension	○		Thyroid
○		Arthritis			Migraines	○		Other: _____
○		Bleeding Disorder	○		Kidney Disorder	○		Hepatitis _____
○		Cancer-Type: _____	○		Seizure	○		MRSA Site: _____
○		Diabetes	○		Stroke			Date: _____
○		GERD/Reflux	○		Renal Disease			
○		Allergies	○		Mental Disease			

Smoking Status

☐ Current every day ☐ Current some days ☐ Former ☐ Never ☐ Unknown

Type: ☐ Cigarettes ☐Chew ☐ Other _____ Units/day _____

Ever tried to quit? ☐ Yes ☐ No Passive smoke exposure? ☐Yes ☐ No

Longest tobacco free _____ Age started _____ Age Quit _____

Alcohol Status

Drinks alcohol ☐ Yes ☐ No ☐ Former

Do you wear glasses? ☐ Yes ☐ No Do you wear hearing aid(s)? ☐ Yes ☐ No

Social History

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow Occupation _____

Race _____ Ethnicity ☐ Hispanic or Latino

If applicable Is the child in daycare? ☐ Yes ☐ No Days per week: _____

Language ☐ English ☐Other _____

Illegal Drug Status

Use drugs ☐ Yes ☐ No ☐ Former Type _____ Frequency _____

Do you have a history of or do you have HIV? ☐ Yes ☐ No