

EASTERN CAROLINA EAR, NOSE, AND THROAT-HEAD AND NECK SURGEONS

Date: ___/___/___ Name: _____ DOB: ___/___/___ Age: _____

CHIEF COMPLAINT/ PROBLEM: _____

SURGERIES PERFORMED IN PAST: _____

MEDICAL PROBLEMS:

- | | |
|---|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO...HEPATITS (A,B or C) _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...HIGH BLOOD PRESSURE _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...ARTHRITIS _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...GASTROINTESTINAL _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...STOMACH ULCERS _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...LIVER _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...PROSTATE _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...HIV/AIDS _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...TUBERCULOSIS _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...MIGRAINES _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...MENTAL ILLNESS _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...HEART DISEASE _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...HEART DEFECTS _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...HEART VALVE PROBLEMS _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...PROSTHETIC IMPLANTS _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...DO YOU REQUIRE ANTIBIOTICS FOR DENTAL WORK? | <input type="checkbox"/> YES <input type="checkbox"/> NO...LUNG DISEASE _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...ASTHMA _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...GLAUCOMA _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...DIABETES _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...KIDNEY DISEASE _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...THYROID DISEASE _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...ANEMIA _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...STROKE _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...EPLIEPSY/SEIZURES _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...HAYFEVER/ALLERGIES _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...DEPRESSION _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...CANCER _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...Other _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...Other _____
<input type="checkbox"/> YES <input type="checkbox"/> NO...Other _____ |
|---|--|

BLEEDING PROBLEMS: Easy bleeding or bleeding after surgery Any blood relatives who are free bleeders

ALLERGIES "FOOD AND/OR DRUG"

LIST MEDICINE OR FOOD IN THIS COLUMN	LIST REACTION IN THIS COLUMN
1) _____	1) _____
2) _____	2) _____
3) _____	3) _____

TOBACCO USE? YES NO If yes, how many packs per day?____, how many years?____, Quit____ years ago.

ALCOHOL USE? YES NO If yes, do you use alcohol on a regular basis? YES NO If yes, how many drinks per day?____

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING? (please check)

- | | | | | | |
|---|---|------------------------------------|---------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> STROKE | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> MIGRAINES | <input type="checkbox"/> CANCER | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> HEART ATTACK |
| <input type="checkbox"/> MENTAL ILLNESS | <input type="checkbox"/> ALLERGIES | | | | |

MEDICATIONS YOU TAKE (including aspirin & herbs)

MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____
MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____
MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____
MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____
MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____
MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____

Reviewed By: _____ MD

Updated: _____

_____	_____	_____
Date/MD	Date/MD	Date/MD
_____	_____	_____
Date/MD	Date/MD	Date/MD

MEDICATIONS Continued

MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____
MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____
MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____
MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____
MEDICATION: _____	DOSAGE: _____	HOW OFTEN: _____

Check each symptom that applies:

None of these apply

Constitutional

fever chills fatigue weight loss

Musculoskeletal

joint pain muscle aches

Gastrointestinal

heartburn trouble swallowing nausea vomiting chronic throat clearing
 foreign body sensation

Respiratory

shortness of breath cough wheezing

Neurological

facial numbness facial weakness facial pain fainting

Endocrine

excessive hunger excessive thirst excessive urination heat or cold intolerance

ENT

ear pain hearing loss throat pain hoarseness nasal blockage altered smell
 nasal bleeding

Allergy/Immunologic

nasal itching watery eyes skin reactions frequent nasal / sinus infections
 watery nasal discharge sneezing postnasal drip
 seasonal symptoms - spring, summer, fall, winter

Skin

skin cancer skin abnormality of head, neck or face dryness

Eyes

visual changes double vision

Psychological

anxiety depression stress

Cardiovascular

chest pain spells of passing out leg swelling

Urinary

excessive frequency of urination pain with urination