LOVELACE MEDICAL GROUP EAR, NOSE & THROAT

Patient Name _____ Age _____ Date _____

Height: ___Ft. ___In Weight _____

What problem brings you to the office today? _____

What medications are you currently taking? (Please include all prescription and non-prescription drugs as well as any herbal, homeopathic or alternative health products)

Prescription Drugs ☐ Check if none	Strength (i.e. 50 mg)	Directions (such as 2 tablets in the a.m.)	
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

Over the Counter & Non Prescription Drugs ☐ Check if none	Strength (i.e. 50 mg)	Directions (such as 2 tablets in the a.m.)	
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

List any allergies to medications or foods

Name of Substance ☐ Check If None	Type of Reaction

List any allergies to pollens or environmental allergens

Name of Substance ☐ Check If None	Type of Reaction

Have you ever had surgery of any kind? Please list type and date.

Type of Surgery ☐ Check If None	Date of Surgery

Have you ever been hospitalized for a prolonged period. Please list reason and date.

Reason for Hospitalization ☐ Check If None	Date of Hospitalization

Do you smoke now? Yes _____ No _____ If so, how many packs per day? _____
If you quit smoking, how many years did you smoke? _____

Do you drink alcohol? Yes _____ No _____ If so, how many drinks per week? _____

Have you ever used IV drugs or cocaine? Yes _____ No _____

LOVELACE MEDICAL GROUP EAR, NOSE & THROAT

Patient Name _____ Age _____ Date _____

Have you ever had any of the following:	If yes, please explain in detail:
Diabetes	Yes ____ No ____ _____
High Blood Pressure	Yes ____ No ____ _____
Anemia	Yes ____ No ____ _____
Blood Clotting Disorder	Yes ____ No ____ _____
Migraine or Cluster Headache	Yes ____ No ____ _____
Any Neurologic Disease	Yes ____ No ____ _____
Stroke or TIA (transient ischemia)	Yes ____ No ____ _____
Severe Sinus Infections	Yes ____ No ____ _____
Disease of the Eyes (glaucoma, etc)	Yes ____ No ____ _____
Disease of the Ears (Meniere's, etc)	Yes ____ No ____ _____
Asthma	Yes ____ No ____ _____
Emphysema (COPD)	Yes ____ No ____ _____
Pneumonia	Yes ____ No ____ _____
Tuberculosis or Pulmonary Disease	Yes ____ No ____ _____
Heart murmur	Yes ____ No ____ _____
Heart Disease (Arteriosclerosis)	Yes ____ No ____ _____
Heart Attack	Yes ____ No ____ _____
Congestive Heart Failure	Yes ____ No ____ _____
Hepatitis	Yes ____ No ____ _____
Any other Liver Disease	Yes ____ No ____ _____
Kidney Stones	Yes ____ No ____ _____
Kidney Failure or Kidney Disease	Yes ____ No ____ _____
Stomach/Esophagus Acid Reflux	Yes ____ No ____ _____
Gastric/Duodenal Ulcer	Yes ____ No ____ _____
Colitis	Yes ____ No ____ _____
Other Gastrointestinal Disease	Yes ____ No ____ _____
Immune Disease, (HIV & others)	Yes ____ No ____ _____
Arthritis	Yes ____ No ____ _____
Rheumatoid Arthritis	Yes ____ No ____ _____
Collagen Vascular Disease	Yes ____ No ____ _____
Cancer (including skin & others)	Yes ____ No ____ _____
Thyroid nodule or disease	Yes ____ No ____ _____
STD (example, Herpes)	Yes ____ No ____ _____
Cold sores (fever blister on lip)	Yes ____ No ____ _____
Other medical conditions not listed	Yes ____ No ____ _____

Please list the present health, or cause of death, of your family member:

Mother _____
Father _____
Sister(s) _____
Brother(s) _____
Children _____

LOVELACE MEDICAL GROUP EAR, NOSE & THROAT

Patient Name _____ Age _____ Date _____

Are you currently suffering from any of the following symptoms:

Constitutional

- O Fevers
- O Chills
- O Weight loss

Eyes

- O Double vision
- O Impaired Vision
- O Changes in Vision
- O Redness

Ears, Nose, Throat

- O Sinus Pain
- O Nose bleeds
- O Ear Pain
- O Ear Discharge
- O Voice change
- O Nasal obstruction
- O Hearing loss
- O Dry mouth
- O Difficulty swallowing
- O Dizziness
- O Tinnitus (ringing in ear)
- O Nasal congestion
- O Sore throat
- O Tinnitus (ringing in ear)
- O Neck swelling
- O Snoring

Cardiovascular

- O Chest pain
- O Irregular heart beats
- O Swelling in legs

Respiratory

- O Cough
- O Shortness of breath
- O Asthma
- O Wheezing

Gastrointestinal

- O Heartburn
- O Nausea
- O Vomiting
- O Constipation
- O Diarrhea

Neurological

- O Headache
- O Seizures
- O Muscular Weakness
- O Memory difficulties
- O Tingling or numbness
- O Loss of consciousness

Musculoskeletal

- O Muscle pain
- O Joint pain

Endocrine

- O Cold Intolerance
- O Heat Intolerance
- O Thyroid problems

Psychiatric

- O Depression
- O Anxiety
- O Delusions

Hematologic/lymphatic

- O Easy bruising
- O Easy bleeding
- O Swollen or tender lymph nodes

Allergic/Immunologic

- O Allergic dermatitis
- O Seasonal allergies
- O Anaphylaxis