

Welcome to ENT of Georgia. Our goal is to provide you or your child with the highest quality 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? _____

Gender: Male Female

- This person is :**
- Primary physician
 - Other physician
 - Non-physician health care provider
 - Friend / other

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 symptoms below which apply to **you**, or **no** for those symptoms that do not apply:

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

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
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Painful / swollen joints	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Weak urine stream	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Sit up to breathe easy	<input type="checkbox"/>	<input type="checkbox"/>	Excessive tearing	<input type="checkbox"/>	<input type="checkbox"/>	Hair / Nail problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Flaking / peeling skin	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Light bothers eyes	<input type="checkbox"/>	<input type="checkbox"/>	Itchy skin	<input type="checkbox"/>	<input type="checkbox"/>
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	High stress	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Shaking / tremor	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>
Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>
Yellow skin	<input type="checkbox"/>	<input type="checkbox"/>	Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Blood from rectum	<input type="checkbox"/>	<input type="checkbox"/>	Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Frequent thirst	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>						
Black tarry stool	<input type="checkbox"/>	<input type="checkbox"/>						

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
Past heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Blocked arteries	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Past stroke	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Home oxygen	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Past bypass surgery	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Have pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
Past angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury	<input type="checkbox"/>	<input type="checkbox"/>	Food allergy	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Contact allergy	<input type="checkbox"/>	<input type="checkbox"/>
Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Myesthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>	Latex allergy	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Adhesive tape allergy	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A / B / C	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant allergy	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Previous skin testing	<input type="checkbox"/>	<input type="checkbox"/>

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 above, please explain. Please tell us anything else we should know:

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

Reviewed by: _____

Please list all prior surgical procedures

Operation	Date

Operation	Date

Medications you take

Include vitamins, supplements, herbals

Name	Dose

Name	Dose

Your Drug Allergies

List all allergies and bad reactions to medications

Name	Reaction

Family History

Please check yes for those illnesses that are present in your immediate blood relatives (parents, children or siblings):

	YES	NO		YES	NO		YES	NO
Heart attack / disease	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Blocked arteries	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell / trait	<input type="checkbox"/>	<input type="checkbox"/>
Past stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problem	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>

Other family illness: if yes, please list:

Social History:

What type of work / school do you do? _____

Who lives with you at home? _____

You smoke _____ packs of cigarettes a day - **OR** - you smoked _____ packs per day, then quit _____ years ago

You consume _____ alcoholic beverages per day / week / month (circle)

You consume _____ caffeine beverages per day (coffee, tea, ice tea, coke, mountain dew, etc.)

You consume _____ glasses of water per day

Is there any chance you may be pregnant? _____

Reviewed by: _____