central oregon
EAR | NOSE | THROAT

Patient Name:___________________________

Date of Birth: ___________________________

Seen at the request of: Today's Date: ___________________________

(Physician/Nurse Practitioner)________________________ Clinic:______________________________________

CHIEF COMPLAINT and HISTORY OF ILLNESSES

What is the reason for your visit today? ____

How long have you had this problem?____

How severe is this problem?____

What makes it better?____

What makes it worse?____

What other symptoms are you having?____

MEDICATIONS (List all your current medications and the dosages)

____ ____
____ ____
____ ____
____ ____

MEDICAL HISTORY	**Yes**	**No**		**Yes**	**No**
High Blood Pressure	________	________	Thyroid Disease	________	________
Kidney Disease	________	________	Hepatitis/Liver Disease	________	________
Diabetes	________	________	Tuberculosis/TB	________	________
Heart Disease/Angina	________	________	HIV/AIDS	________	________
Asthma/Emphysema/	(*please circle*)		Rheumatic Fever	________	________
Stroke/Mini-stroke	________	________	Arthritis	________	________
Cancer (list type & date below)	________	________	Others:________________________		

____

ALLERGIES Are you allergic to tape, iodine and/or latex?____

List allergies to medications and food. Include a description of what happens.___________________________

____

____

SURGICAL HISTORY	**Yes**	**No**		**Yes**	**No**
Surgery for Cancer	________	________	Heart Surgery	________	________
Mastectomy	________	________	Lung Surgery	________	________
Skin Cancer Surgery	________	________	Colon Removal	________	________
Sinus Surgery	________	________	Neck/Spine	________	________
Tonsillectomy	________	________	Others:________________________		

____

RADIOLOGY List the dates for the following radiology tests:

Head X ray: ______________________________ Thyroid X ray: ______________________________

CT/MRI Scans: ____________________________ Upper GI/ Barium Swallow:____________________

REVIEW OF SYSTEMS

	YES	NO		YES	NO
Ringing R Ear	_____	_____	Hoarseness	_____	_____
Ringing L Ear	_____	_____	Throat Clearing	_____	_____
Dizziness	_____	_____	Swallowing pain	_____	_____
Pain in R Ear	_____	_____	Discomfort in throat	_____	_____
Pain in L Ear	_____	_____	Something in Throat	_____	_____
Drainage from R Ear	_____	_____	Cough	_____	_____
Drainage from L Ear	_____	_____	Heartburn/Sour taste	_____	_____
Hearing loss R Ear	_____	_____	White balls on tonsils	_____	_____
Hearing loss L Ear	_____	_____	Large tonsils	_____	_____
Nasal congestion	_____	_____	Itchy nose/ears/eyes	_____	_____
Nasal drainage	_____	_____	Runny/watery eyes	_____	_____
Facial pain	_____	_____	Sneezing fits	_____	_____
External facial deformity	_____	_____	Runny nose	_____	_____
Nasal bleeding (*please circle*)	Right	Left	Scratchy throat	_____	_____
Loud snoring	_____	_____			
Stop breathing while asleep	_____	_____	Lump in neck	_____	_____
Excess daytime sleepiness	_____	_____	Skin cancers	_____	_____
Blood in stool	_____	_____	Neck/back pain	_____	_____
Vomiting	_____	_____	Loss of sensation	_____	_____
Nausea	_____	_____	Paralysis of arm/leg	_____	_____
Recent weight loss	_____	_____	Loss of speech	_____	_____
Fevers/Chills	_____	_____	Facial droop	_____	_____
Night sweats	_____	_____	Fatigue	_____	_____
Chest pain/tightness	_____	_____	Shortness of breath	_____	_____
Poor circulation	_____	_____	Wheezing	_____	_____
Irregular heartbeat	_____	_____	Others: ______________________________		

FAMILY HISTORY

	YES	NO		YES	NO
Hearing loss	_____	_____	Stroke	_____	_____
High blood pressure	_____	_____	Diabetes	_____	_____
Cancer	_____	_____	Bleeding problems	_____	_____
Alcoholism	_____	_____	Heart Attack	_____	_____
Psychiatric Illness	_____	_____	Anesthesia Reaction	_____	_____

Others: ____

SOCIAL HISTORY

Occupation: ______________________________

Have you worked in a noisy environment? ____________

Exposure to loud noises? ____________________

If so, what kind? ______________________________

Do you smoke? ____________________________

How much do you smoke?____________________________

Are you thinking about quitting? ____________

When did you quit? ______________________________

How much alcohol do you drink each day? ____

List any street drug use: ____

Do you have an advanced directive? ____