central oregon
EAR | NOSE | THROAT

Today's Date: ______________________

Name: ______________________ **Date of Birth:** ______________________

Seen at the request of:

Dr./Nurse Practitioner: ______________________ Clinic: ______________________

Preferred Language: ______________________ Race: ❑ American Indian/Alaskan Native ❑ Asian

Ethnicity: ❑ Hispanic or Latino ❑ Native Hawaiian/Other Pacific Islander ❑ White

❑ Not Hispanic or Latino ❑ Black/African American ❑ Hispanic

Chief Complaint / History of Illness:

What is the reason for today's visit? ______________________

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 dosage)

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Allergies: (List medications/foods and what happens) ______________________

____

____

Allergies to tape, iodine or latex: ______________________

List the dates for the following radiology tests:

Head X ray: ______________________

Thyroid X ray: ______________________

CT/MRI Scans: ______________________

Upper GI/ Barium Swallow ______________________

Allergy Testing:

When? ______________________

Clinic? ______________________

Immunotherapy? Y N

Social History:

Occupation: ______________________

Have you worked in a noisy environment? ________ If so, what kind? ______________________

Exposure to loud noises? ______________________ Other: ______________________

Do you smoke? ________ Do you chew? ________ How much? ______________________

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? ______________________

centMH 2/16

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Past Medical History:

	Yes	No
High blood pressure	______	______
Kidney disease	______	______
Diabetes	______	______
Thyroid disease	______	______
Tuberculosis/TB	______	______
Rheumatic Fever	______	______
Arthritis	______	______

Please circle if applicable:

Heart Disease / Angina / Asthma / Emphysema
Stroke / Mini stroke / Liver disease
Hepatitis A B C / HIV / AIDS
Cancer: *(list type & date below)* ____________________
____
____
Others: ____________________

Past Surgical History:

	Yes	No
Surgery for cancer	______	______
Mastectomy	______	______
Skin cancer surgery	______	______
Sinus surgery	______	______
Tonsillectomy	______	______
Heart surgery	______	______
Lung surgery	______	______
Colon removal	______	______
Neck/spine	______	______

Others: ____________________

Review of Symptoms:

	Yes	No
Ringing R Ear	______	______
Ringing L Ear	______	______
Dizziness	______	______
Pain in R Ear	______	______
Pain in L Ear	______	______
Drainage from R Ear	______	______
Drainage from L Ear	______	______
Hearing loss R Ear	______	______
Hearing loss L Ear	______	______
Nasal congestion	______	______
Nasal drainage	______	______
Facial pain	______	______
External facial deformity	______	______
Nasal bleeding *(please circle)*	Right	Left
Loud snoring	______	______
Stop breathing while asleep	______	______
Excessive daytime sleepiness	______	______
Blood in stool	______	______
Vomiting	______	______
Nausea	______	______
Recent weight loss	______	______
Fevers/Chills	______	______
Night sweats	______	______
Fatigue	______	______
Chest pain/tightness	______	______
Poor circulation	______	______
Irregular heartbeat	______	______

	Yes	No
Hoarseness	______	______
Throat clearing	______	______
Swallowing pain	______	______
Discomfort in throat	______	______
Something in throat	______	______
Cough	______	______
Heartburn/Sour taste	______	______
White balls on tonsils	______	______
Large tonsils	______	______
Itchy nose/ears/eyes	______	______
Runny/watery eyes	______	______
Sneezing fits	______	______
Runny nose	______	______
Scratchy throat	______	______
Skin cancers	______	______
Neck/back pain	______	______
Loss of sensation	______	______
Paralysis of arm/leg	______	______
Loss of speech	______	______
Facial droop	______	______
Shortness of breath	______	______
Wheezing	______	______

Others: ____________________

Family History

	Yes	No
Hearing loss	______	______
High blood pressure	______	______
Cancer	______	______
Alcoholism	______	______
Psychiatric Illness	______	______

Others: ____________________

	Yes	No
Stroke	______	______
Diabetes	______	______
Bleeding problems	______	______
Heart Attack	______	______
Anesthesia reaction	______	______