SOUTHERN E.N.T. ASSOCIATES, INC.

The Sinus, Ear, Nose, Throat, and Plastic Surgery Specialists

Weight: ________________

Height: ________________

Patient Intake Form

Name: ____ Date Of Birth: ______________________

What medical problem brings you here today? ____________________________________

- Location of Symptom(s):____
- How severe is the problem: 1 2 3 4 5 6 7 8 9 10
- How long have you had the problem? ______________________________________
- When does it occur or recur? ____
- Is it made better or worse with any treatments? _____________________________
- List any associated symptom(s). ____

- **PAST MEDICAL HISTORY**

Ear, Nose & Throat:
□ Ear Infections
□ Sinus Infections
□ Allergies
□ Throat Problems
□ Voice Problems
□ Swimmers Ear

Eyes
□ Glaucoma
□ Cataracts

Heart:
□ Heart Attack
□ Irregular Heartbeat
□ Abnormal Heart Valve
□ High Blood Pressure

Lung:
□ Asthma
□ COPD
□ Tuberculosis
□ Emphysema
□ Sleep apnea

Gastrointestinal:
□ Reflux
□ Stomach problems
□ Hepatitis
□ Cirrhosis
□ Hiatal Hernia

Kidney:
□ Kidney Failure
□ Incontinence
□ Prostate Problems
□ Bladder Problems

Neurologic:
□ Stroke
□ Headaches
□ Seizures
□ Multiple Sclerosis

Psychiatric:
□ Depression
□ Anxiety

Endocrine:
□ Diabetes
□ Thyroid Problems

Hematologic:
□ Anemia
□ Bleeding Disorder

Dermatologic:
□ Keloids
□ Skin Conditions

Rheumatologic:
□ Arthritis
□ Fibromyalgia
□ Autoimmune Disorder
□ Osteoporosis

Infectious:
□ HIV
□ Lyme disease
□ Mononucleosis

Oncologic:
□ Cancer: List Type(s)
____
____
____
____

Other: ____

- **PAST SURGICAL HISTORY**

Ear, Nose & Throat:
□ Tonsillectomy/Adenoidectomy
□ Ear Surgery
□ Nose/Sinus Surgery
□Tracheotomy

Heart:
□ Bypass
□ Stent
□Valve Surgery
□ Carotid Artery
□ Pacemaker
□ Other

Lung:
□ Bronchoscopy
□ Lung Surgery

Gastrointestinal:
□ Surgery for reflux
□ Stomach Surgery
□ Intestinal Surgery
□ Gall bladder

Orthopedic:
□ Fracture
□ Knee Replacement
□ Hip replacement
□ Back Surgery

Pelvic:
□ Prostate
□ Bladder
□ D&C
□ Gyn Surgery
□ Kidney Surgery

Other:
□ Breast
□ Neurosurgery
□ Eye

- **MEDICATIONS**

Please list **ALL** medications (or provide list on separate paper). Please include over the counter medications.

MEDICATION	DOSE	REASON

PLEASE TURN OVER →

- **ALLERGIES**

Please list all allergies to medications and foods:

□ **No Allergies**

ALLERGY	**REACTION**
______________________________	____
______________________________	____
______________________________	____

- **FAMILY HISTORY**

Check if any of these run in the family (only those related by blood):

□ Autoimmune Disease □ Diabetes □ High Blood Pressure
□ Bleeding/Coagulation Disorder □ Thyroid Disease □ Tuberculosis
□ Heart Disease □ Hearing Loss □ Problems with Anesthesia

- **SOCIAL HISTORY**

Marital Status: □ Single □ Married/Partnered □ Divorced □ Other
Occupation: Current: ______________________________________Previous: __________________________________
Noise Exposure: □ at Work □ In military □ Noise from Hobbies
Tobacco: □ Never Smoked □ Current Smoker: Amount: _____ per day # years smoking _____ □ Former Smoker: Stopped _____
Alcohol: □ Never Drank Alcohol □ Drink currently □ Beer □ Wine □ Liquor Amount per day ___________
□ Former drinker stopped ________
Caffeine: □ Coffee Oz/ day: ______ □ Tea Oz/ day: ______ □ Caffeinated soft drinks Oz/ day: ______

- **SPECIAL CONCERNS**

□ Pregnant (Due: ____________) □ Breastfeeding □ Taking Blood Thinners □ Require antibiotics for procedures □ Latex allergy

- **REVIEW OF SYSTEMS**

Check other active symptoms

Constitutional:
☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Loss
☐ Loss of Appetite

Cardiovascular
☐ Cheat Pain
☐ Fainting
☐ Irregular Heart

Respiratory:
☐ Shortness of Breath
☐ Cough
☐ Coughing up blood
☐ Wheezing

Eyes:
☐ Recent Change in Vision
☐ Per-Orbital Swelling

Gastrointestinal:
☐ Trouble Swallowing
☐ Heartburn
☐Bloody Vomiting

Genitourinary:
☐ Urinary Retention

Integument:
☐ Changes to Existing Skin Lesion

Psychiatric:
☐ Anxiety
☐ Depression

Neurologic:
☐ Weakness
☐ Seizures
☐ Numbness

Endocrine:
☐ Heat Intolerance
☐ Cold Intolerance

Hematology / Lymphatic:
☐ Easy Bleeding
☐ Excessive Bleeding with Previous Surgeries
☐ Easy Bruising

☐ **Allergy / Immunology:**
☐ Eczema
☐ Asthma
☐ Allergic Conjunctivitis (red eyes)

Head/Ears/Nose/Throat
☐ Headache
☐ Vertigo (Spinning Sensation)
☐ Dizziness
☐ Lightheadedness
☐ Recent Head Injury
☐ Sinus Pain
☐ Nasal Obstruction
☐ Nasal Congestion
☐ Nosebleeds
☐ Nasal Discharge
☐ Ear Discharge
☐ Ear Fullness
☐ Itching in Ear
☐ Ear Swelling
☐ Pressure Sensation in Ear
☐ Deviated Septum
☐ Decreased Sense of Smell
☐ Snoring
☐ Oral Ulcers
☐ Oral Sores
☐ Nasal Pain
☐ Purulent Nasal Discharge
☐ Gingival Bleeding
☐ Dental Problems
☐ Dentures
☐ Neck Stiffness
☐ Neck Pain
☐ Neck Tenderness
☐ Thyroid Mass
☐ Sore Throat
☐ Breath Odor
☐ Ear Pain
☐ Hearing Loss
☐ Ringing in Ears
☐ Roaring Sound in Ear
☐ Pulsatile Tinnitus
☐ Oral Blisters
☐ Oral White Spots
☐ Mouth Pain
☐ Dry Mouth
☐ Enlarged Tonsils
☐ Frequent Throat Cleaning
☐ Lump in Throat
☐ Hoarseness
☐ Change in Voice
☐ Difficulty Swallowing
☐ Neck Mass
☐ Swollen Glands
☐ Neck Swelling
☐ Hearing Aid

Patient Signature: ____ Date: _______________