Onslow Ear Nose & Throat

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Name	**DOB**

***ALLERGIES** (medications, X-Ray Dyes, latex) *Please state type of reaction*

***PRESCRIPTION MEDICATIONS**-name, dosage ☐SEE LIST *REMEMBER TO BRING ALL MEDICATIONS TO FUTURE VISITS*		

Social History	
Do you use tobacco products? *☐ Former ☐Never ☐Yes _____ per day _____years*	*Pediatric Patients:* *Exposure to smoke? ☐NO ☐YES*
Do you drink alcohol? *☐ Former ☐Never ☐Yes _____type _____amount (circle one: daily, weekly, monthly)*	

PAST MEDICAL HISTORY				
*PREGNANT OR THINK YOU MAY BE PREGNANT? ☐YES ☐NO *PLEASE LET US KNOW IF YOUR PREGNANCY STATUS CHANGES*				
☐ Acid reflux (GERD)	*☐Birth Defect*	*☐Developmental Delay*	*☐Kidney disease*	*☐Sleep apnea*
☐ Anemia	*☐Bleeding/Clotting Disorder*	*☐Diabetes*	*☐Liver cirrhosis*	*☐Stroke/TIA*
☐Anxiety	*☐Cancer Type:*	*☐Heart Disease*	*☐Migraines*	*☐Thyroid Disorder*
☐Asthma	*☐COPD/Emphysema*	*☐High blood pressure*	*☐Seasonal allergies*	*☐Tinnitus*
☐Autoimmune Disorder	*☐Depression*	*☐Insomnia*	*☐Seizures*	*☐Vertigo/Dizziness*
Other:				

PAST SURGICAL HISTORY				
☐ Ear tubes	*☐Septoplasty*	*☐Tympanoplasty*	*☐Head/Neck Cancer Surgery*	*☐Eye Surgery*
☐ Tonsillectomy	*☐Terbinate reduction*	*☐Mastoid surgery*	*☐Heart Surgery*	*☐Other*
☐ Adenoidectomy	*☐Sinus surgery*	*☐Sleep Apnea Surgery*	*☐Pacemaker Placement*	

***FAMILY HISTORY** ☐ADOPTED (PLEASE SKIP THIS SECTION) *PLEASE LIST ONLY BLOOD-RELATED FAMILY MEMBERS*				
	Father	*Mother*	*Sibling(s)*	*Child(ren)*
Anesthesia Problem	*☐*	*☐*	*☐*	*☐*
Bleeding/Clotting disorder	*☐*	*☐*	*☐*	*☐*
Cancer (list the type)	*☐*	*☐*	*☐*	*☐*
Heart disease	*☐*	*☐*	*☐*	*☐*
Hearing Disorder	*☐*	*☐*	*☐*	*☐*
Other:	*☐*	*☐*	*☐*	*☐*

PLEASE CHECK THE PROBLEMS THAT APPLY TO YOU:		
Ear Problems	*Nose Problems*	*Throat Problems*
☐Ear ache ☐Right ☐Left	*☐Stuffiness/Blockage*	*☐Sore throat*
☐Dizziness/Vertigo	*☐Postnasal Drip/Runny nose*	*☐Swollen glands*
☐Injury to Ear	*☐Nosebleeds*	*☐Hoarseness*
☐Ear drainage	*☐Snoring*	*☐Coughing up blood*
☐Hearing Loss ☐Gradual ☐Sudden	*☐Loss of Smell*	*☐Difficulty swallowing*
☐Ringing in Ears	*☐Sneezing*	*☐Bad breath*
☐Other	*☐Other*	*☐Other*