SOUTHERN UTAH EAR, NOSE, THROAT, AUDIOLOGY, ALLERGY and FACIAL PLASTICS

Name_____ Birth Date_____

Date_____

Chief complaint or illness:

1. What is the reason for today's visit? _____

_____.

2. How long have you had this problem? _____
3. How severe is this problem? 1 2 3 4 5 6 7 8 9 10

MILD **VERY SEVERE**

4. Have you had your hearing tested in the last year? **YES NO** Is it ever difficult to understand speech? **YES NO**
5. Have you had more than one sinus infection in the last year? **YES NO** Do you ever experience sinus pressure? **YES NO**
6. Do you have any hoarseness or changes in your voice? **YES NO** Do you have soreness or difficulty swallowing? **YES NO**
7. Do you suffer from allergies such as hay fever, asthma, eczema, or food allergies? (circle appropriate items) If yes, describe:

_____.

Have **you** or a **family member** ever had the following?

	You	Mother	Father	Brother(s)	Sister(s)
Anesthesia Reactions ……	____	_____	_____	_____	_____
Blood Clots – DVT/PE …	_____	_____	_____	_____	_____
Bleeding Tendency ……	_____	_____	_____	_____	_____
Diabetes ……	_____	_____	_____	_____	_____
Deceased?	_____	_____	_____	_____	_____

Please list any other chronic illnesses or diseases you have: _____

_____.

List all previous surgeries Month/Year ☐ **See Attached List**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies

1._____ Reaction: _____

2._____ Reaction: _____

Medications (List all current medications, the dose you take, and how often.) ☐ **See Attached List**

1._____ Dose_____ 6._____ Dose_____

2._____ Dose_____ 7._____ Dose_____

3._____ Dose_____ 8._____ Dose_____

4._____ Dose_____ 9._____ Dose_____

5._____ Dose_____ 10._____ Dose_____

Social History:

Occupation _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

How many children do you have? _____ If a child, do you live at home with ☐ Both Parents ☐Mother ☐ Father

Do you smoke or use tobacco? ☐**YES** ☐**NO** (☐Cigarettes ☐Cigars ☐Pipe ☐Chewing Tobacco)

If yes … How much? (Packs per day)_____ for _____years.

Do you Vape? If so what kind do you use_____ and how often? _____

Did you quit smoking? ☐**YES** ☐**NO** If yes, WHEN? _____

Do you use alcoholic beverages? ☐**YES** ☐**NO** How much and how

frequently?_____

List any street drugs you have used: _____

Do you have any drug or alcohol addictions? ☐**YES** ☐**NO**

Do you have any reason to believe you are at risk for HIV, AIDS, or HEPATITIS? ☐**YES** ☐**NO**

REVIEW OF SYSTEMS:

(Please check any of the following that you are **CURRENTLY EXPERIENCING** or **BEING TREATED FOR**)

Constitutional

☐ Recent weight change ☐ Fever, Chills ☐ Fatigue

Eyes: **ENT:**

☐ Double vision ☐ Hearing loss ☐ Nose drainage ☐ Swallowing pain
☐ Loss of vision ☐ Ringing in ears ☐ Nasal Congestion ☐ Voice change
☐ Eye pain ☐ Dizziness ☐ Facial pain ☐ Snoring
☐ Eye disease or injury ☐ Ear pain ☐ Headaches ☐ Hoarseness
☐ Wear contacts or glasses ☐ Ear drainage ☐ Sore mouth/throat ☐ Poor sleep

Cardiovascular / Pulmonary

☐ Chest Pain ☐ Heart attack ☐ Irregular heartbeat ☐ Feeling faint/lightheaded
☐ Poor circulation ☐ Leg pain during walking ☐ Coughing up blood
☐ Shortness of breath ☐ Wheezing ☐ Unusual shortness of breath while climbing stairs

Gastrointestinal

☐ Stomach ulcers ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation
☐ Blood in stool ☐ Trouble swallowing ☐ Abdominal pain

Genitourinary

☐ Blood in urine ☐ Pain during urination ☐ Difficulty making urine ☐ Kidney stones

Musculoskeletal

☐ Neck/Spine injury ☐ Neck or back disorder ☐ Arthritis

Neurological

☐ Stroke ☐ Mini stroke (TIA) ☐ Temporary loss of vision or speech control
☐ Loss of sensation ☐ Paralysis of an arm or leg ☐ Facial paralysis

Skin

☐ Skin cancers ☐ Dermatitis/Eczema

Psychiatric

☐ Clinical depression ☐ Anxiety ☐ Schizophrenia
☐ Hallucinations ☐ Other psychiatric disorder (list)_____

Infectious Disease

☐ Hepatitis ☐ HIV/AIDS ☐ Mononucleosis ☐ TB
☐ Herpes ☐ Syphilis ☐ Gonorrhea ☐ Chlamydia

Have you ever had the following?

☐ Measles ☐ Mumps ☐ Chicken Pox