Prescott Ear, Nose, Throat and Allergy

DISEASES AND SURGERY OF THE EAR, NOSE & THROAT
HEAD AND NECK SURGERY — ALLERGY
MARK D. STRASSER, MD - DEREK K. HEWITT, MD

Patient Name: _____ Age:_____ Insurance:_____
Last seen in our office:_____ Family Doctor_____ Referring Physician_____
Height:_____ft_____in Weight:_____lbs

Do you currently have any of the following symptoms?

General	No	Yes
Fevers	☐	☐
Fatigue	☐	☐
Night sweats	☐	☐
Weight gain/loss	☐	☐

Ear	No	Yes
Itching	☐	☐
Pain	☐	☐
Fullness/Pressure	☐	☐
Hearing Loss	☐	☐
Ringing	☐	☐

Nose	No	Yes
Congestion	☐	☐
Post nasal drip	☐	☐
Facial Pain	☐	☐
Runny nose	☐	☐
Loss of smell	☐	☐

Throat	No	Yes
Difficulty swallowing	☐	☐
Heartburn	☐	☐
Throat pain	☐	☐
Hoarseness	☐	☐

Skin	No	Yes
Rash	☐	☐
Itching	☐	☐
Excess scarring	☐	☐
Bleeding problems	☐	☐

Neurologic	No	Yes
Severe headaches	☐	☐
Numbness/tingling	☐	☐
Transient paralysis	☐	☐
Poor memory	☐	☐

Vestibular	No	Yes
Light headed	☐	☐
Spinning sensation	☐	☐
Falling	☐	☐
Joint pain	☐	☐

Eyes	No	Yes
Itching	☐	☐
Blurring	☐	☐
Double vision	☐	☐

Neck	No	Yes
Lump/mass	☐	☐

Respiratory	No	Yes
Cough	☐	☐
Shortness of breath	☐	☐
Chest pain	☐	☐

List all medicines you are currently taking, with their dosages.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any medical **allergies**?
Yes ☐ No ☐
If yes, please list medicine & its reaction.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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❖ Do you have or have you had any of the following medical conditions?

	Current	Past		Current	Past		Current	Past
Adverse anesthetic effects	☐	☐	Allergic Rhinitis	☐	☐			
			Anemia	☐	☐	Anxiety	☐	☐
Arthritis	☐	☐	Asthma	☐	☐	Atrial fibrillation	☐	☐
Heart Failure	☐	☐	Clotting Disorder	☐	☐	Depression	☐	☐
Diabetes	☐	☐	Emphysema	☐	☐	Gout	☐	☐
Genetic Bleeding Hx	☐	☐	Heart Attack	☐	☐	Heartburn	☐	☐
High Blood Pressure	☐	☐	High Cholesterol	☐	☐	Hypothyroid	☐	☐
Insomnia	☐	☐	Kidney Failure	☐	☐	Migraine	☐	☐
Osteoporosis	☐	☐	Stroke	☐	☐	Peripheral Vascular Disease	☐	☐

Do you have any other medical conditions not listed above? Please list them.

_____ _____
_____ _____
_____ _____

❖ Please list all surgeries that you have undergone:

_____ _____
_____ _____
_____ _____
_____ _____

❖ Do you have a family history of any of the following? Please circle.

Adverse anesthetic effects	Clotting Disorder		
Allergic rhinitis	Anxiety	Asthma	Diabetes
Coronary artery disease	Circulatory disorder	Depression	Emphysema
Hearing loss	High blood pressure	Heart attack	High cholesterol
Thyroid cancer	Migraine	Osteoporosis	Stroke

Add any other family history problems below.

_____ _____
_____ _____

Yes No

❖ Do you smoke? ☐ ☐ If yes: Packs per day____ Number of years_____
Former Smoker ☐ When did you stop smoking? _____
Never smoked ☐
Chew Tobacco? ☐ ☐

Do you drink alcohol?
No Infrequently Frequently

Do you use any recreational or other type of drugs?
Yes No If yes, what type? _____

❖ If a child, is the child up-to-date with his/her immunizations? Yes No