Patient Medical History

Patient Name: _____ Date of Birth: _____

Pharmacy Name & Location: _____

Reason for today's visit: _____

Referring Provider/Primary Care: _____

Past Medical History: check ALL that apply, including past and current diagnoses		
☐ High Blood Pressure	☐ Heart Attack (MI) Date:	☐ Stroke
☐ Atrial Fibrillation	☐ Coronary Artery Disease	☐ Kidney Failure
☐ Asthma	☐ Bleeding Disorder	☐ DVT
☐ Sleep Apnea	☐ COPD/Chronic Bronchitis	☐ HIV
☐ Acid Reflux	☐ Diabetes Most recent HbA1C:	☐ Hepatitis B or C
☐ Cancer Type & Location: ☐ Chemotherapy ☐ Radiation Treatment	Other Medical Problems not Listed Above:	

Past Surgeries Pertaining to ENT: check ALL that apply, include the years the surgery was performed					
	Year		Year		Year
☐ Ear Tubes		☐ Tympanoplasty		☐ Mastoidectomy	
☐ Septoplasty		☐ Rhinoplasty		☐ Sinus Surgery	
☐ Tonsillectomy		☐ Adenoidectomy		☐ Thyroidectomy	
☐ Cardiac Stents		☐ Heart Surgery		☐ Gastric bypass or banding	
☐ Kidney Transplant		☐ Skin Cancer Location of Skin Cancer:			
Other Surgery not Listed Above:					

Family History: check ALL that apply			
	Family Member Affected		Family Member Affected
☐ Asthma		☐ Thyroid Cancer	
☐ Bleeding Disorder, Type:		☐ Other Cancer Type:	
☐ Hearing Loss:		☐ Heart Attack	
☐ Problems with Anesthesia		☐ Stroke before age 60	
Additional Family History:			

Please list all current medications, including over-the-counter

Medications _____

_____

_____

Medication Allergies (please specify if mild, medium or severe)_____

_____

_____

Review of Systems

PDX ENT & AUDIOLOGY MEDICAL GROUP

Patient Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____

Social History:

Do you currently use	**Are you** (please circle one)
Tobacco	Employed Workplace/Employer:
If so how much per day?	Yes No
Alcohol	Marital Status:
If so how much per day?	

Please check yes or no if you CURRENTLY have the following symptoms

ENT	**Yes**	**No**		**Yes**	**No**
Hearing Loss			Facial Pain		
Ringing in the ears			Loss of smell		
Room spinning dizziness			Postnasal drip		
Ear pain			Snoring		
Ear discharge			Difficulty swallowing		
Runny nose			Pain with swallowing		
Problem with nasal breathing			Hoarseness		
Itchy nose			Nosebleeds		
Lump in neck					

Neurologic	**Yes**	**No**	**Cardiovascular**	**Yes**	**No**
Headaches			Chest pain		
Numbness			Irregular Heartbeat		
Weakness			Shortness of breath		
Blurred Vision					
Double Vision					

Musculoskeletal	**Yes**	**No**	**Skin**	**Yes**	**No**
Joint Pain			Dry Skin		
Joint Swelling			Concerning Mole		
Limited Mobility			Itchy Skin		

General	**Yes**	**No**	**Genitourinary**	**Yes**	**No**
Fever			Frequent Urination		
Recent Weight Loss			Nocturnal Urination		
Night Sweats			Painful Urination		
Fatigue					