THE EAR, NOSE & THROAT CENTER, AMC

Please list all medical history
(I.e., High B/P, Diabetes, Cancer)

_____

_____

_____

_____

_____

Please list all surgeries

_____

_____

_____

Please list all medications, including over the counter

_____

_____

_____

Allergies:

_____

_____

Social History: Marital status _____ Education level _____
Employment _____
Tobacco _____ Alcohol _____ Drugs _____

Family History: Bleeding disorders _____ Diabetes _____
Heart disease _____ Cancer _____
Thyroid disorder _____ Other: _____

Have you ever tested positive to or been exposed to Tuberculosis (TB)? Yes _____ No _____

Please check (√) symptoms you have had within the past six weeks:

General
Fever/chills _____
Weight loss/gain _____
Fatigue _____
Night sweats _____

Eyes
Change in vision _____
Double vision _____
Glaucoma _____

Ears, Nose, Mouth & Throat
Hearing loss _____
Ear pain/drainage ____
Sinus problems _____
Hoarseness _____

Allergic
Nasal obstruction _____
Itching _____
Unusual infection _____

Genito-Urinary
Pain on urination _____
Frequent urination _____
Kidney stones _____

Other _____

_____

Respiratory
Cough _____
Wheezing _____
Noisy breathing _____
Short of breath _____
Snoring _____

Cardiovascular
Chest pains _____
Palpitations _____
Edema (swelling) _____
Previous heart attack _____

Gastrointestinal
Indigestion _____
Trouble swallowing _____
Nausea/vomiting _____
Ulcers _____
Blood in stool _____

Musculoskeletal
Muscle aches _____
Joint stiffness _____
Broken bones _____

Skin/Breast
Rashes _____
Abnormal hair/nail growth _____
Breast lumps/discharge _____

Neurological
Dizziness _____
Fainting _____
Seizures _____
Weakness _____

Psychological
Nervousness _____
Depression _____
Mood changes _____

Endocrine
Thyroid enlargement _____
Heat/cold intolerance _____

Hematology/Lymph
Anemia _____
Blood clots _____
Jaundice _____
Easy-bruising _____
Enlarged lymph nodes _____

_____

_____

_____

_____

NAME: _____ **DOB:** _____ **DATE:** _____