EAR, NOSE & THROAT ASSOCIATES

DRS. DIEHN, KUNAR, KAPLAN, DUBIN, FLETCHER, WOOD & HAHN.

TODAY'S DATE: _____

* The following information is for use by your health care provider as part of your **confidential medical record.** The following information is also very important to your health. Please take time to fully and accurately fill out this form.

NAME: _____ ☐ Male ☐ Female DATE OF BIRTH _____

REASON for YOUR VISIT: _____

_____

_____

_____

_____

_____

Past Medical History and Review of Systems:
Please check (✓) if you have had problems with or are presently experiencing any of the following:

- ☐ Doubled/blurred vision
- ☐ Glaucoma/cataract
- ☐ Ringing in the ears
- ☐ Hearing loss
- ☐ Recurring sinus infections
- ☐ Frequent nose bleeds
- ☐ Allergies/hay fever
- ☐ Difficulty swallowing
- ☐ Difficulty chewing food
- ☐ Asthma/wheezing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough up blood
- ☐ Tuberculosis exposure
- ☐ Positive PPD
- ☐ Other lung problems
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Heart murmur
- ☐ Chest pain/tightness
- ☐ High blood pressure
- ☐ Heart disease/failure
- ☐ High cholesterol
- ☐ Have a pacemaker?
- ☐ Swollen ankles
- ☐ Leg pain with walking
- ☐ Stroke
- ☐ Dizziness/fainting
- ☐ Heartburn/indigestion
- ☐ Stomach ulcers
- ☐ Persistant vomiting
- ☐ Persistant nausea
- ☐ Gallbladder disease
- ☐ Liver disease
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Crohn's disease
- ☐ Bleeding tendencies
- ☐ Blood clots
- ☐ Anemia
- ☐ Frequent urination
- ☐ Prostate problems
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Urinary tract infections
- ☐ Syphilis
- ☐ HIV positive
- ☐ Gonorrhea/Chlamydia
- ☐ Herpes
- ☐ Sleep difficulty
- ☐ Snoring
- ☐ Daytime drowsiness
- ☐ Fatigue
- ☐ Unexplained weight gain/loss
- ☐ Mole changes
- ☐ Cancer Type? _____
- ☐ Thyroid problems
- ☐ Heat or cold tolerance
- ☐ Diabetes
- ☐ Headache/Migraine
- ☐ Head injury
- ☐ Tremor/hand shaking
- ☐ Seizures
- ☐ Muscle weakness/pain
- ☐ Numbness
- ☐ Arthritis
- ☐ Tick Bites
- ☐ Osteoporosis
- ☐ Gout
- ☐ Eczema
- ☐ Psoriasis
- ☐ Unhealed sores
- ☐ Chronic rashes
- ☐ Nervousness
- ☐ Depression
- ☐ Memory loss
- ☐ Phobias

If need be, please explain problems further in the spaces below: _____

_____

_____

_____

PLEASE → COMPLETE → OTHER → SIDE →

PLEASE LIST ALL MEDICATION YOU TAKE:

Include over-the-counter medicine, vitamins, herbal supplements, & diet aids.

Drug name	Dose	Drug name	Dose	Drug name	Dose

Do you take aspirin? ❑ Yes ❑ No

PLEASE LIST ANY ALLERGIES TO MEDICATION: Do you have any latex allergies? ❑Yes ❑ No

PLEASE EXPLAIN THE FOLLOWING:

Are you?: married single divorced widow What is your occupation? _____

Have you recently traveled abroad? ❑ No ❑ Yes If so, please describe where, when & for how long?

Have you received blood transfusions? ❑ No ❑ Yes if so, when? _____

Smoke?	Drink Alcohol?	Drink Coffee/Tea?	Exercise?
❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
How many packs per day? _____	How many drinks per week? _____	How many cups/day? _____	How often? _____

HOSPITALIZATION/SURGICAL HISTORY:

Please list any illnesses or operations that require hospitalization:

Year	Illness/Operation	Year	Illness/ Operation	Year	Illness /Operation

FAMILY HISTORY: Please list the family member who is affected with the following condition.

Anemia:_____ Asthma:_____ Allergies:_____
Bleeding tendency:_____ Heart Attack:_____ Diabetes:_____
Thyroid problem: _____ Stroke:_____ Cancer: _____
High blood pressure: _____ Migraines: _____ Early hearing loss: _____
Other: _____

*** The above is true and correct to the best of my belief. PLEASE SIGN BELOW**

Patient/Guardian signature: _____ Date: _____

Office use only: ANNUAL UPDATE I reviewed health history and medications with the patient:

Date & initials: _____ Date & initials: _____ Date & initials: _____
Date & initials: _____ Date & initials: _____ Date & initials: _____
Date & initials: _____ Date & initials: _____ Date & initials: _____