Welcome to ENT & Allergy Specialists of Shady Grove

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

EARS

Ear Pain	O Yes	O No
Ear Pressure	O Yes	O No
Dizziness	O Yes	O No
Ringing in Ears	O Yes	O No
Discharge	O Yes	O No
Noise Exposure	O Yes	O No
Hearing Loss	O Yes	O No
Lightheadedness	O Yes	O No

NOSE

Injury	O Yes	O No
Surgery	O Yes	O No
Blockage	O Yes	O No
Headache	O Yes	O No
Post Nasal Drip	O Yes	O No
Discharge	O Yes	O No
Bleeding	O Yes	O No
Snoring	O Yes	O No
Unable to Smell	O Yes	O No
Sinusitis	O Yes	O No
Sleep Apnea	O Yes	O No
Using CPAP?	O Yes	O No

THROAT

Soreness	O Yes	O No
Difficulty Swallowing	O Yes	O No
Painful Swallowing	O Yes	O No
Lump in Throat	O Yes	O No
Hoarseness/Change in Voice	O Yes	O No

ALLERGY

Hayfever	O Yes	O No
Asthma	O Yes	O No
Skin Test	O Yes	O No
Allergy Shots	O Yes	O No

EYES

Watery Eyes	O Yes	O No
Blind Spots	O Yes	O No
Light Sensitive	O Yes	O No
Blurry/Visual Loss	O Yes	O No
Glasses/Contacts	O Yes	O No
Cataracts	O Yes	O No
Dry Eyes	O Yes	O No

CARDIOLOGY

Chest Pain	O Yes	O No
High Blood Pressure	O Yes	O No

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

RESPIRATORY

Cough	O Yes	O No
Pneumonia	O Yes	O No
Shortness of Breath	O Yes	O No

NEUROLOGY

Stroke	O Yes	O No
Weakness	O Yes	O No
Headache	O Yes	O No
Seizures	O Yes	O No

HEMATOLOGY/LYMPH

Bruising	O Yes	O No
Bleeding	O Yes	O No
Plavix usage?	O Yes	O No
Coumadin usage?	O Yes	O No
Aspirin usage?	O Yes	O No
NSAID usage?	O Yes	O No
Clotting problems	O Yes	O No

CONSTITUTIONAL

Fever	O Yes	O No
Weight Loss	O Yes	O No
Fatigue	O Yes	O No

GASTROENTEROLOGY

Constipation	O Yes	O No
Nausea	O Yes	O No
Abdominal Pain	O Yes	O No
Heartburn	O Yes	O No
Blood in Stool	O Yes	O No
Regurgitation	O Yes	O No
Vomiting	O Yes	O No
Diarrhea	O Yes	O No

MUSCULOSKELETAL

Aches	O Yes	O No
Weakness	O Yes	O No
Arthritis	O Yes	O No

Family History

Father	O None	O Allergies	O Asthma	O Bleeding Disorders	O Cancer
	O Hearing Loss	O Heart Disease		O High Blood Pressure	O Diabetes
Mother	O None	O Allergies	O Asthma	O Bleeding Disorders	O Cancer
	O Hearing Loss	O Heart Disease		O High Blood Pressure	O Diabetes
Siblings	O None	O Allergies	O Asthma	O Bleeding Disorders	O Cancer
	O Hearing Loss	O Heart Disease		O High Blood Pressure	O Diabetes
Children	O None	O Allergies	O Asthma	O Bleeding Disorders	O Cancer
	O Hearing Loss	O Heart Disease		O High Blood Pressure	O Diabetes

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

Social History

Martial Status: O Married O Single O Divorced O Widowed

Occupation: O Full time O Part time O Retired O Homemaker O Student

O Unemployed

Smoking: O Yes O No O Trying to Quit

Alcohol: O Yes O No O Social drinker

O Trying to Quit O Recovering Alcoholic

Recreational Drugs: O Yes O No

HIV Infected: O Yes O No O Status Unknown

Medical History

(Please **CIRCLE** any of the conditions that may relate to you currently)

DIABETIC

CARDIAC PATIENT	HYPOTHYROIDISM	PREGNANT
MAO INHIBITOR	RENAL FAILURE	LIVER DISEASE
RECENT MONO	ANTICOAGULANTS	HIGH BLOOD PRESSURE
HYPERTHYROIDISM	ASTHMA	ANTIBIOTICS PRIOR TO DENTAL
OTHER MEDICAL HISTORY_____	BREASTFEEDING	CANCER_____

ALLERGIES TO MEDICATIONS: _____

_____

☐ **No Known Drug Allergies**

LIST ALL CURRENT MEDICATIONS: _____

_____

_____

_____

LIST ALL PAST SURGERIES: _____

_____

_____