**Welcome to ENT & Allergy Specialists of Shady Grove**

ENT & FACIAL PLASTIC SURGERY 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:** _____

_____

_____