

# Tucson Ear, Nose & Throat, P.C.

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## Please Fill Out Regarding your General Health

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Primary care physician: \_\_\_\_\_

**CHIEF COMPLAINT (Primary reason for visit):** \_\_\_\_\_

### **Past Medical History:**

*Check the following disorders that you have had:*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Inhalant(nasal) allergies  | <input type="checkbox"/> Immunological Disorders | <input type="checkbox"/> Food Allergies         |
| <input type="checkbox"/> Chest Pain(angina)   | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Heart Murmur           |
| <input type="checkbox"/> Congestive heart failure   | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Artificial Heart Valve |
| <input type="checkbox"/> Irregular Heart Beat   | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Emphysema  | <input type="checkbox"/> COPD                    | <input type="checkbox"/> Tuberculosis(TB)       |
| <input type="checkbox"/> Glaucoma   | <input type="checkbox"/> Cataracts               | <input type="checkbox"/> Eczema                 |
| <input type="checkbox"/> Seizures   | <input type="checkbox"/> Thyroid Disorder        | <input type="checkbox"/> Hemorrhoids            |
| <input type="checkbox"/> Hepatitis <input type="checkbox"/> A, <input type="checkbox"/> B, <input type="checkbox"/> C | <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Peptic Ulcer           |
| <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Anxiety Disorder        | <input type="checkbox"/> Hearing Aids           |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Kidney Problems         |   |

Cancer: Type \_\_\_\_\_

Other medical problems: \_\_\_\_\_

### **Past Hospitalizations/Surgeries:**

**Date:**

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

<b><u>Current Medication(s)</u></b>	<b>Dose/Frequency</b>	<b><u>Current Medication(s)</u></b>	<b>Dose/Frequency</b>
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1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

5) \_\_\_\_\_ 6) \_\_\_\_\_

**Allergies to Medications (INCLUDE LATEX ALLERGY)**

None known

<i>Medicine</i>	<i>Type of reaction(e.g. rash)</i>
1) _____	_____
2) _____	_____
3) _____	_____

**Have you ever had a problem with anesthesia?**

\_\_\_ No, I've had it and no problems \_\_\_ Never had it before \_\_\_ Yes

If yes, please explain: \_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_

Do you smoke? \_\_\_ cigarettes \_\_\_ cigars \_\_\_ chew \_\_\_ pipe  
 \_\_\_ Never \_\_\_ Use to smoke \_\_\_ packs/day for \_\_\_ years but quit \_\_\_ years ago  
 \_\_\_ Currently smoke \_\_\_ packs/day for \_\_\_ years

Do you drink alcohol? \_\_\_ Never \_\_\_ Less than once a month \_\_\_ Daily \_\_\_ Weekly  
 \_\_\_ No, but use to drink

Are you at risk for AIDS/Hepatitis? (e.g. Sexual orientation, IV drug use, previous blood transfusion) If yes, please explain: \_\_\_\_\_

Do you use caffeine (coffee, tea, soda, etc.)? If yes, describe: \_\_\_\_\_

Rate your weekly stress level from 1-10 (1 is no stress, 10 is high stress) \_\_\_\_\_

Describe your stressors? \_\_\_\_\_

Females: Are you pregnant, planning a pregnancy, or nursing a child? \_\_\_\_\_

**Family History:**

Do you have any blood relatives with the following;

Hearing Loss	Yes	No	Who? _____
Cancer	Yes	No	Who/What Kind? _____
Heart Disease	Yes	No	Who? _____
Stroke	Yes	No	Who? _____
Diabetes	Yes	No	Who? _____
Depression	Yes	No	Who? _____
Anxiety Disorder	Yes	No	Who? _____

**Review of systems:**

**Constitutional:** N/A Recent weight change Fever  
Fatigue Chills Night sweats

**Eyes:** N/A Loss of vision Pain Discharge/Tearing  
L  R Both L  R Both L  R Both

**Ears, Nose, Mouth Throat:**

- N/A  
Itchy ears      Facial weakness      nasal obstruction      nasal drainage  
Nose bleed      Sneezing      Stuffy nose      Snoring  
Loss of smell      Growth in nose      Mouth growth,ulcer      Drooling  
Chewing difficulty      Lump in neck      Dental problems      Pain on swallowing  
Heartburn      Sore throat      bleeding from throat      Voice changes  
Breathing difficultly      Hearing loss

**Cardiovascular:**

- N/A      Chest pain      Irregular heart beat  
swelling of legs      Leg pain with Walking      Leg pain with rest

**Respiratory:**

- N/A      Wheezing      Cough  
Shortness of breath      Mucous      coughing up blood

**Gastrointestinal:**

- N/A      Decrease in appetite      Nausea/Vomiting  
Blood in stool      Difficulty swallowing      Indigestion  
Food intolerance      Diarrhea/constipation

**Musculoskeletal:**

- N/A      Neck Pain      Joint pain/stiffness  
Arthritis      Name joints

**Skin:**

- N/A      Rash      Jaundice  
Recent baldness

**Neurologic:**

- N/A      Headache      Blackout  
Seizure      Paralysis      Tremor  
Memory loss

**Psychogenic:**

- N/A      Insomnia      Depression  
On medication      Yes      No

**Endocrine:**

- N/A      Thyroid nodule      Heat or cold intolerance  
Excessive sweating      Excessive thirst, hunger urination

**Genitourinary:**

- N/A      Painful urination      Venereal disease  
Blood in urine      Frequent urination at night      Incontinence  
Difficulty passing urine

**Hematologic/Lymphatic:**

- N/A      Anemia      Bleeding problems  
Easy bruising      Blood disorders

The above information is accurate to the best of my knowledge.

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Patient Signature

Name (Printed)

Date

I have reviewed the above information with the patient.

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Physician Signature

Name (Printed)

Date