Welcome to ENT of Georgia. Our goal is to provide you and your family with the highest of care. The first step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete all pages of the form below. Our staff would be glad to help you if necessary. The care we give you can be no better than the information your provide.

Name _____ Age: _____ Date of Birth: _____
First MI Last MM/DD/YYYY

Gender ◯ Male ◯ Female

Who sent you to us today? _____

This person is: ◯ Primary Physician
◯ Other Physician
◯ Non-physician healthcare provider
◯ Friend/Other

Primary Physician (name and phone number)

_____

_____

Pharmacy Name and Phone Number

_____

Please name the major problem or symptom that brings you to us today: _____

Please describe the history of your present illness in detail:

_____

_____

_____

_____

_____

Rate the severity of today's symptoms on a 1-10 scale (10=worst): _____

How long have your symptoms been present? _____

What makes your symptoms worse **or** better? _____

What other providers have you seen for this illness? _____

What diagnostic tests have been performed so far?

◯ X-Ray ◯ Ultrasound ◯ Hearing Test ◯ NONE
◯ CT Scan ◯ Swallow Study ◯ Biopsy
◯ MRI ◯ Allergy Testing ◯ Other _____

What treatments have been tried so far (include any operations done for this illness)?

◯ Antibiotics ◯ Pain Medications
◯ Allergy Medications ◯ Other _____
◯ Reflux Medications ◯ NONE

Please check those symptoms below which apply to your current complaint:

◯ Headache ◯ Loss of smell/taste ◯ Heartburn
◯ Decreased vision ◯ Hearing loss ◯ Neck mass/swollen glands
◯ Eye pain ◯ Ringing in ears ◯ Snoring
◯ Double vision ◯ Ear pain ◯ Stop breathing during sleep
◯ Nasal congestion ◯ Ear drainage ◯ Sleepy in the daytime
◯ Facial pain ◯ Dizzy/off balance ◯ Throat Pain
◯ Nasal discharge ◯ Ear fullness/pressure ◯ Neck Pain
◯ Post-nasal drip ◯ Difficulty swallowing ◯ NONE
◯ Frequent sneezing ◯ Can't clear throat
◯ Nasal obstruction ◯ Cough
◯ Nosebleed ◯ Hoarseness

Review of Systems

Please check the symptoms below which apply to YOU, and you are CURRENTLY experiencing:

- ◯ Check here if none of the below symptoms apply to you

GENERAL:
- ◯ Fever/Chills
- ◯ Weight loss
- ◯ Night Sweats

EYES:
- ◯ Light bothers eyes
- ◯ Irritated eyes
- ◯ Eyes crust/drain

CARDIOVASCULAR:
- ◯ Chest Pain
- ◯ Irregular hearbeat

RESPIRATORY:
- ◯ Shortness of breath
- ◯ Wheezing
- ◯ Cough up blood

GASTROINTESTINAL:
- ◯ Abdominal pain
- ◯ Bloody/black stool
- ◯ Nausea/vomiting
- ◯ Diarrhea
- ◯ Yellow Jaudice
- ◯ Indigestion

GENITOURINARY:
- ◯ Painful urination
- ◯ Weak urine stream
- ◯ Blood in urine

MUSCULOSKELETAL:
- ◯ Painful/swollen joints
- ◯ Back Pain

SKIN:
- ◯ Rash
- ◯ Hair/nail problems
- ◯ Flaking/peeling skin

NEUROLOGIC:
- ◯ Weakness
- ◯ Shaking/tremor
- ◯ Fainting

PHYSCHOLOGICAL:
- ◯ High stess/anxiety
- ◯ Depression
- ◯ Mood swings

ENDOCRINE:
- ◯ Cold intolerance
- ◯ Heat intolerance
- ◯ Frequent thirst

BLOOD:
- ◯ Anemia
- ◯ Bruise easily
- ◯ Prolonged bleeding
- ◯ HIV Risk Factors

Past Medical History

Please check the below illnesses you have or have had in the past:

EYES:
- ◯ Glaucoma
- ◯ Cataract
- ◯ Macular degeneration

CARDIOVASCULAR:
- ◯ High blood pressure
- ◯ Past heart attack
- ◯ Prior stroke
- ◯ Blocked arteries
- ◯ Heart failure
- ◯ Mitral valve prolapse
- ◯ Past bypass surgery
- ◯ Have pacemaker
- ◯ Prior angioplasty

RESPIRATORY:
- ◯ Obstructive sleep apnea
- ◯ Asthma
- ◯ COPD/emphysema
- ◯ Tuberculosis
- ◯ Pneumonia
- ◯ Use of oxygen at home

GASTOINTESTINAL:
- ◯ Reflux
- ◯ Hiatal hernia
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C

MUSCULOSKELETAL:
- ◯ Fibromyalgia
- ◯ Gout
- ◯ Arthritis

NEUROLOGIC:
- ◯ Seizure Disorder
- ◯ Parkinson's disease
- ◯ Spinal Injury
- ◯ Head Injury
- ◯ Meningitis

PSYCHIATRIC:
- ◯ Mental health problems
- ◯ Anxiety
- ◯ Depression
- ◯ INFECTIONS:

ENDOCRINE:
- ◯ Low thyroid
- ◯ Overactive thyroid
- ◯ Thyroid nodule
- ◯ Thyroid cancer
- ◯ Diabetes - diet control
- ◯ Diabetes - oral meds
- ◯ Diabetes - insulin

IMMUNOLOGIC:
- ◯ HIV Positive

CD4 count: ____ Viral load: ____

Do you have a history of cancer (circle one)? YES NO

If yes, please specify: _____

Other Significant Illness: _____

_____

_____

Vaccinations:

Have you had a **pneumonia vaccination?** ◯ YES ◯ NO DATE:_____

Have you had a **flu vaccine**(within 12 months)? ◯ YES ◯ NO DATE:_____

Medications (include vitamins, supplements, herbals)

◯ I consent to **ALL** electronic Prescriptions

List ALL Medications you take:

Name of Medication:	Dosage:

Allergies List all FOOD, CONTACT, INHALANT, & DRUG Allergies

◯ I HAVE NO KNOWN DRUG ALLERGIES

◯ Latex Allergy

Name:	Reaction:

Surgical History:

◯ I HAVE HAD NO OPERATIONS/SURGICAL PROCEDURES

◯ PE Tubes
◯ Middle Ear Surgery
◯ External Ear Surgery
◯ Tonsillectomy
◯ Adenoidectomy
◯ Septoplasty
◯ Turbinate Reduction
◯ Sinus Surgery
◯ Rhinoplasty
◯ Sleep Apnea
◯ Vocal Cord Surgery
◯ Airway Surgery
◯ Thyroid Surgery
◯ Parotid Surgery
◯ Neck Surgery
◯ Mastoidectomy
◯ Tympanoplasty

◯ Other (Include date) _____

_____

_____

Family History: Please check those illnesses that are present in your immediate blood relatives (parents, siblings, children):

◯ Unknown/Adopted
◯ Heart attack/disease
◯ Blocked arteries
◯ Past stroke
◯ Allergies
◯ High Blood Pressure
◯ Diabetes
◯ Thyroid problems
◯ Cancer
◯ Hearing Loss
◯ Sickle Cell/trait
◯ Bleeding problem
◯ Asthma
◯ NONE
◯ Other: _____

Social History:

What type of work/school do you do? _____

Who lives with you at home?

◯ Live Alone
◯ With Spouse/Partner
◯ With Parents
◯ With Children
◯ With Other Family Member(s)
◯ With Friend(s)/Roomate(s)
◯ Shelter
◯ In an Assisted Living Facility
◯ With a Dog
◯ With a Cat
◯ Other: _____

Have you ever or do you currently smoke or use tobacco products in any form? ◯ YES ◯ NO

Cigarette/E-Smoke/Cigar/Chewing (circle) ____ packs/day Quit? ____ Years Smoked _____ packs/day

Are you exposed to second hand smoke? ◯ YES ◯ NO

Do you consume: Alcoholic Beverages ◯ YES ◯ NO _____/day/week/month (circle)

Water ◯ YES ◯ NO _____ Glasses per day

Caffeine(coffee/tea/soda) ◯ YES ◯ NO _____ Beverages per day

Is there any chance you may be pregnant? ◯ YES ◯ NO ◯ N/A

Height: _____ Weight: _____

Patient Signature (Guardian if patient is a minor) **Date**