

FAUQUIER EAR NOSE & THROAT CONSULTANTS, PLC

☞ DON'T FORGET TO SIGN BOTTOM OF 2nd PAGE!!!

Your Name: _____ Date of Birth: _____ Age: _____

Circle all medical problems you have had both in past and present and than list any not mentioned:

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|--------------------|---------------|------------------------|------------------------|---------------|
| Diabetes | Heart Failure | Asthma | Hypertension | Reflux |
| Heart Attack | Stroke | Embolic Events | Bleeding Problems | Renal Disease |
| Coronary Artery Dz | COPD | Peripheral Vascular Dz | Cancer (specify below) | Hepatitis |

List **ALL** surgeries along with approximate year performed (include ear tubes, sinus surgery, tonsillectomy, etc).

List all **ALLERGIES** to medications (use back if needed): No Known Drug Allergies

Preferred Pharmacy: _____ City and Street: _____

How many years have you **SMOKED**? _____ Never Smoked If you smoke, how many packs per day? _____
 If you quit smoking, what year did you stop? _____

How often do you drink **ALCOHOL**? Never / Daily / Weekly / Rarely Do you drink **CAFFIENE** daily? Yes / No

List all medications with dosages you take: No medications

Family History (hearing loss <45 years old, cancer, thyroid problems, etc)?:

All Immediate Family Members	Medical Problems	If deceased, cause of death?	If deceased, at what age?
Mother	<input type="checkbox"/> hearing loss at a young age <input type="checkbox"/> history of cancer		
Father	<input type="checkbox"/> hearing loss at a young age <input type="checkbox"/> history of cancer		
	<input type="checkbox"/> hearing loss at a young age <input type="checkbox"/> history of cancer		
	<input type="checkbox"/> hearing loss at a young age <input type="checkbox"/> history of cancer		

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Current Review of Symptoms:

Constitutional (Circle All That Applies to You):

Shaking Chills	Sudden Decreased Activity	Decreased Appetite	Fatigue	Insomnia
Irritability	Lethargy	Night Sweats	Pallor	Weakness
Weight Gain	Weight Loss	Fussiness		

Respiratory (Circle All That Applies to You):

Cough	Shortness of Breath	Hemoptysis (Coughing up Blood)
Pain with Breathing	Snoring	Coughing up Mucus
Stridor (Noisy Breathing)	Wheezing	Frequent Upper Respiratory Infections
Known TB (Tuberculosis) Exposure		

Gastrointestinal (Circle All That Applies to You):

Bloating	Change in Bowel Habits	Constipation	Decreased Appetite
Diarrhea	Flatulence (Gassy)	Heartburn	Nausea
Reflux	Odynophagia (Pain with Swallowing)		

Metabolic/Endocrine (Circle All That Applies to You):

Overweight	Underweight	Cold Intolerance	Decreased Activity
Goiter	Heat Intolerance	Tremors	Voice Changes

Neuro / Psych (Circle All That Applies to You):

Dizziness	Trouble Talking Clearly	Light-Headedness	Memory Impairment
Fainting Spells	Seizures	Speech Changes	Change in Vision

Dermatologic (Circle All That Applies to You):

Contact Allergy	Pruritis (Itching)	Rash	Head & Neck Skin Lesions
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Hematologic (Circle All That Applies to You):

Easy Bleeding	Easy Bruising	History of Blood Clots Inside the Body
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Immunology (Circle All That Applies to You):

Animals in the Home	Animals in the Workplace	Chemical Exposure in Home/Workplace
Asthma	Contact Dermatitis	Food Allergies

Please circle all that applies to you:

Recent travel to third world countries	Permanent Tattoos
Multiple sexual partners and/or high risk sexual activity	Body Piercings (other than the ear)
Illicit drug use (please list)	

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

Patient's Signature (or Parent/Guardian)

Date