University of Florida College of Medicine – Jacksonville **MRN: _____**
Otolaryngology Head and Neck Surgery (Ear, Nose & Throat)

Patient Name: _____
Today's Date: _____

Name: _____ Age: _____
Email: _____
Primary Care/Family physician name: _____
Pharmacy (name & location): _____
Reason for Today's Visit: _____

Past Medical History: (Check/Circle all that Apply)

Are all your immunizations up to date? Y / N

Please check any below conditions which may affect you currently or in the past:

	Headaches		Heart attack		Hearing Loss
	Migraines		Coronary artery disease		Ear infections
	Diabetes		High blood pressure		Occupational noise exposure
	Asthma		Stroke		Depression
	COPD/ Emphysema		Chronic sinus infections		Bleeding Disorder(s): (sickle cell, hemophilia…)
	Tuberculosis		High cholesterol		
	Thyroid problems		Skin (cancer, rash)		History of Cancer – type:
	Liver problems		Gout		
	HIV/ Hepatitis B,C		Rheumatoid arthritis		Other(s) (please describe):
	GERD/ Reflux		Osteoarthritis		

Past Surgical History:

Have you had any previous surgeries? Y / N

	Surgery	Year		Surgery	Year
1.			4.		
2.			5.		
3.			6.		

Allergies:

Medications:

1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

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Patient Name: _____
Today's Date: _____

Social History:

Marital Status (please circle): Single Married Divorced Separated Widowed
Number of Children: _____
Employed/Unemployed/Retired/Disabled Occupation:

Currently use tobacco (cigarettes, chewing tobacco) Y / N If YES, how much daily? How long?	**Previous Smoker?** Y / N When did you quit?
Do you drink alcohol? Y / N If YES, how much per day/week?	**Past Alcohol Use?:** Y / N If YES, quit When?
Current Street Drug Use? Y / N If YES, what type:	**Past History of Drug Use?** Y / N If YES, what type?

Family History: (Check all that apply)

	Headaches		Heart Attack		Hearing Loss
	Migraine		Coronary Artery Disease		Ear Infections
	Diabetes Mellitus		High Blood Pressure		Occupational Noise Exposure
	Asthma		Stroke		Increased Cholesterol/Lipids
	COPD/ Emphysema		Sinus Disease/ Infections		Depression
	Tuberculosis		Hepatitis		Bleeding Disorder
	Thyroid Disease		Skin Disorders (cancer, rash)		History of Cancer – type:
	Liver Disease		Gout		
	HIV/ Hepatitis B,C		Rheumatoid Arthritis		Other (please describe):
	GERD/ Reflux		Osteoarthritis		

Review of Systems: (Please check all that apply)

	unintentional weight loss		Nosebleeds		Sinus Tenderness
	Fever/chills		Nasal Congestion		Sinus Infections
	Night sweats		Post-nasal Drip		Dry Mouth
	Recent change in vision		Heart Palpitations		Sore Throat
	Dizziness		Cough		Difficulty Swallowing
	Ear Pain		Swelling in legs/ankles		Pain with Swallowing
	Decreased Hearing		Passing/ blacking out		Lump in Throat
	Ears Popping		Wheezing		Decreased sense of smell
	Hoarseness		Shortness of Breath		Headache
	Drainage from Ears		Loss of taste		Facial Pain/ Pressure
	Ringing in Ears		Nausea/ Vomiting		Loss of Consciousness
			Heartburn		Dizziness
			Regurgitation of Food		Itchy Eyes
			Acid Reflux		Watery Eyes
	TMJ/ Jaw Pain		Thyroid Problems		Itchy Nose
	Clench/ Grind Teeth		Thyroid Goiter		Itchy Ears
	Abnormal Taste in Mouth		Light-Headedness		Sneezing
	Burning Mouth		Easily Bruising		
	Burning Tongue		Bleeding Disorder		
	Rashes		Lymph Node Swelling		