EASTERN CAROLINA EAR, NOSE AND THROAT-HEAD AND NECK SURGEONS

Eastern Carolina Ear, Nose & Throat- Head & Neck Surgery, PA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Date:___/___/___ Name:______________________________ DOB:___/___/___ Age:_____

REASON FOR VISIT:____

PAST SURGERIES:____

HEIGHT:____________ **WEIGHT:**___________

MEDICAL PROBLEMS:

☐ YES ☐ NO…HEPATITIS (A, B, OR C) ______________________
☐ YES ☐ NO…HIGH BLOOD PRESSURE____________________
☐ YES ☐ NO…ARTHRITIS________________________________
☐ YES ☐ NO…GASTROINTESTINAL________________________
☐ YES ☐ NO…STOMACH ULCERS__________________________
☐ YES ☐ NO…LIVER______________________________________
☐ YES ☐ NO…PROSTATE___________________________________
☐ YES ☐ NO…HIV/AIDS___________________________________
☐ YES ☐ NO…TUBERCULOSIS_____________________________
☐ YES ☐ NO…MIGRAINES_________________________________
☐ YES ☐ NO…MENTAL ILLNESS___________________________
☐ YES ☐ NO…HEART DISEASE____________________________
☐ YES ☐ NO…HEART DEFECTS_____________________________
☐ YES ☐ NO…HEART VALVE PROBLEMS_____________________
☐ YES ☐ NO…PROSTHETIC IMPLANTS________________________
☐ YES ☐ NO…LUNG DISEASE ______________________
☐ YES ☐ NO…ASTHMA ____________________________
☐ YES ☐ NO…GLAUCOMA __________________________
☐ YES ☐ NO…DIABETES ____________________________
☐ YES ☐ NO…KIDNEY DISEASE ______________________
☐ YES ☐ NO…THYROID DISEASE_____________________
☐ YES ☐ NO…ANEMIA ______________________________
☐ YES ☐ NO…STROKE________________________________
☐ YES ☐ NO…EPILEPSY/SEIZURES ___________________
☐ YES ☐ NO…HAYFEVER/ALLERGIES _________________
☐ YES ☐ NO…DEPRESSION___________________________
☐ YES ☐ NO…CANCER ______________________________
☐ YES ☐ NO…SLEEP APNEA _________________________
☐ YES ☐ NO…OTHER _______________________________
☐ YES ☐ NO…OTHER _______________________________
☐ YES ☐ NO…DO YOU REQUIRE ANTIBIOTICS FOR DENTAL WORK?
☐ YES ☐ NO…BLEEDING PROBLEMS: ☐ Easy bleeding or bleeding after surgery ☐ Any blood relatives who are free bleeders

ALLERGIES: List medicine or food and Reaction

1)____
2)____
3)____
4)____
5)____

Tobacco Use:

☐ currently smokes
☐ has smoked in the past
☐ never smoked
☐ former smoker

Alcohol Use:

☐ never
☐ occasional
☐ daily
☐ social

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING? (please check)

☐ TUBERCULOSIS
☐ HYPERTENSION
☐ MENTAL ILLNESS
☐ EPILEPSY
☐ KIDNEY DISEASE
☐ ALLERGIES
☐ ARTHRITIS
☐ MIGRAINES
☐ GLAUCOMA
☐ HEARING LOSS
☐ CANCER
☐ DIABETES
☐ STROKE
☐ HEART ATTACK

REVIEW OF SYMPTOMS:
Check each symptom that applies:

***	☐ None of these apply
Constitutional	☐ fever ☐ chills ☐ fatigue ☐ weight loss
Musculoskeletal	☐ joint pain ☐ muscle aches
Gastrointestinal	☐ heart burn ☐ trouble swallowing ☐ nausea ☐ vomiting ☐ chronic throat clearing ☐ foreign body sensation
Respiratory	☐ shortness of breath ☐ cough ☐ wheezing
Neurological	☐ facial numbness ☐ facial weakness ☐ facial pain ☐ fainting
Endocrine	☐ excessive hunger ☐ excessive thirst ☐ excessive urination ☐ heat or cold intolerance
ENT	☐ ear pain ☐ hearing loss ☐ throat pain ☐ hoarseness ☐ nasal blockage ☐ altered smell ☐ nasal bleeding
Allergy/Immunologic	☐ nasal itching ☐ watery eyes ☐ skin reactions ☐ frequent nasal/sinus infections ☐ watery nasal discharge ☐ sneezing ☐ postnasal drip ☐ seasonal symptoms- spring, summer, fall, winter
Skin	☐ skin cancer ☐ skin abnormality of head, neck, or face ☐ dryness
Eyes	☐ visual change ☐ double vision
Psychological	☐ anxiety ☐ depression ☐ stress
Cardiovascular	☐ chest pain ☐ spells of passing out ☐ leg swelling
Urinary	☐ excessive frequency of urination ☐ pain with urination

MEDICATIONS YOU TAKE (including aspirin & herbs)

MEDICATION:______________________________**DOSAGE:**_______________**HOW OFTEN:**_____________
MEDICATION:______________________________**DOSAGE:**_______________**HOW OFTEN:**_____________
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MEDICATION:________________________________**DOSAGE:**________________**HOW OFTEN:**______________

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