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 you provide.

Name: ______________________ Age: ________ Date of Birth: ____________
First MI Last MM/DD/YYYY

Who sent you to us today? ____________________

This person is: ☐ Primary Physician
☐ Other Physician
☐ Non-physician health care provided
☐ Friend/Other

Gender: ☐ Male ☐ Female

Primary physician (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? ____________

____

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

____
____

Please check YES for those symptom below which apply to **YOU,** or NO for those symptoms that do not apply:

	YES	NO		YES	NO		YES	NO
Severe headache	☐	☐	Nasal obstruction	☐	☐	Difficulty swallowing	☐	☐
Failing vision	☐	☐	Nosebleed	☐	☐	Can't clear throat	☐	☐
Eye pain	☐	☐	Loss of smell/taste	☐	☐	Cough	☐	☐
Double vision	☐	☐	Hearing loss	☐	☐	Hoarseness	☐	☐
Nasal congestion	☐	☐	Ringing in ears	☐	☐	Heartburn	☐	☐
Facial pain	☐	☐	Ear pain	☐	☐	Neck mass/swollen glands	☐	☐
Nasal discharge	☐	☐	Ear drainage	☐	☐	Snoring	☐	☐
Post-nasal drip	☐	☐	Dizzy/off balance	☐	☐	Stop breathing during sleep	☐	☐
Frequent sneezing	☐	☐	Ear fullness/pressure	☐	☐	Sleepy in the daytime	☐	☐

Reviewed by: ____________________

Review of Systems:

Please check YES for those symptoms below which apply to **YOU,** and NO for those symptoms that do not apply.

	YES	NO		YES	NO		YES	NO
Fever/Chills	☐	☐	Abdominal pain	☐	☐	Weakness	☐	☐
Weight loss	☐	☐	Nausea/vomiting	☐	☐	Shaking/tremor	☐	☐
Night sweats	☐	☐	Yellow jaundice	☐	☐	Fainting	☐	☐
			Bloody/black stool	☐	☐			
Light bothers eyes	☐	☐	Diarrhea	☐	☐	High stress	☐	☐
Irritated eyes	☐	☐				Depression	☐	☐
Eyes crust/drain	☐	☐	Painful urination	☐	☐	Mood swings	☐	☐
			Weak urine stream	☐	☐			
Chest pain	☐	☐	Blood in urine	☐	☐	Cold intolerance	☐	☐
Irregular heartbeat	☐	☐				Heat intolerance	☐	☐
			Painful/swollen joints	☐	☐	Frequent thirst	☐	☐
Shortness of breath	☐	☐	Back pain	☐	☐			
Wheezing	☐	☐				Anemia	☐	☐
Cough up blood	☐	☐	Rash	☐	☐	Bruise easily	☐	☐
			Hair/nail problems	☐	☐	Prolonged bleeding	☐	☐
			Flaking/peeling skin	☐	☐			
			Itchy skin	☐	☐	HIV Risk Factors	☐	☐

Past Medical History

Please check YES for those illnesses you **have** or **have had in the past.** Check NO for those illnesses you **have never had:**

	YES	NO		YES	NO		YES	NO
Glaucoma	☐	☐	Reflux	☐	☐	Low thyroid	☐	☐
Cataract	☐	☐	Hiatal hernia	☐	☐	Overactive thyroid	☐	☐
Macular degeneration	☐	☐	Hepatitis A	☐	☐	Thyroid nodule	☐	☐
			Hepatitis B	☐	☐	Thyroid cancer	☐	☐
High blood pressure	☐	☐	Hepatitis C	☐	☐	Diabetes – diet control	☐	☐
Past heart attack	☐	☐				Diabetes – oral meds	☐	☐
Past stroke	☐	☐	Fibromyalgia	☐	☐	Diabetes - insulin	☐	☐
Blocked arteries	☐	☐	Gout	☐	☐			
Heart failure	☐	☐	Arthritis	☐	☐	Food allergy	☐	☐
Mitral valve prolapse	☐	☐				Contact allergy	☐	☐
Past bypass surgery	☐	☐	Seizure disorder	☐	☐	Latex allergy	☐	☐
Have pacemaker	☐	☐	Parkinson's disease	☐	☐	Adhesive tape allergy	☐	☐
Past angioplasty	☐	☐	Spinal injury	☐	☐	Inhalant allergy	☐	☐
			Head injury	☐	☐	Previous skin tests	☐	☐
Obstructive sleep apnea	☐	☐	Meningitis	☐	☐			
Asthma	☐	☐				Bleeding disorder	☐	☐
COPD/Emphysema	☐	☐	Mental Health problems	☐	☐	Use aspirin	☐	☐
Tuberculosis	☐	☐				Use Coumadin	☐	☐
Pneumonia	☐	☐	HIV positive	☐	☐	Use Plavix	☐	☐
Use oxygen at home	☐	☐				Use non-steroidal (such as ibuprofen, Aleve)	☐	☐
						Use other blood thinner	☐	☐

Please list all food, contact and inhalant allergies.
Do **not** include drug allergies. Include any prior skin test results:

____

____

If you answered **YES** to any of the above, please explain. Please tell us anything else we should know about your medical history:

____

____

____

Do you have any history of cancer? ________ If yes, please list site(s) and treatment:

____

____

Have you had a pneumonia vaccination? ☐ YES ☐ NO DATE: ________________________

Reviewed by: ______________________________

Name: ______________________________ DOB: ________________________ Date: ________________________

Surgical History:
Please list ALL prior surgical procedures:

Operation:	Date:	Operation:	Date:

Medications you TAKE:
Include vitamins, supplements & herbals
☐ **I Consent to ALL Electronic Prescription Transactions**

Drug Name:	Dosage:

Medication/Food ALLERGY
List allergies & bad reactions to medications/food
Latex Allergy ☐ YES ☐ NO

Drug/Food Name:	Reaction:

Pharmacy Name and Phone Number: ____

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

☐ Heart attack/heart disease
☐ Blocked arteries
☐ Past Stroke
☐ Allergies
☐ High Blood Pressure
☐ Diabetes
☐ Thyroid problems
☐ Cancer
☐ Hearing Loss
☐ Sickle cell/trait
☐ Bleeding problem
☐ Asthma

Social History:
What type of work/school do you do? ____

Who lives with you at home? ____

Do you smoke?

☐ Yes, _____packs of cigarettes per day
☐ Quit _____years ago, smoked _____packs per day
☐ Never

You consume _____alcoholic beverages per day/week/month (circle).

You consume _____caffeine beverages per day (coffee, tea, iced tea, soda, etc.).

You consume _____glasses of water per day.

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

Height: _____________ Weight: _____________

_______________________________________ Date: ____________________________
Patient signature (Guardian if patient is a minor)