SCOTTSDALE EAR, NOSE & THROAT

Review of Symptoms

Date: _____

Patient Name: _____ **Date of Birth:** _____

Please check yes if you currently have any of the following symptoms.

ENT:	Yes	No	Comments		Yes	No	Comments
Hearing Loss				Facial Pain			
Ringing in the ears				Loss of smell			
Room spinning dizziness				Postnasal drip			
Ear pain				Snoring			
Ear discharge				Difficulty swallowing			
Runny nose				Pain with swallowing			
Hard to breathe through nose				Hoarseness			
Itchy nose				Nose bleeds			
Lump in neck				Sore Throat			
Coughing up blood							

Neurologic	Yes	No	Comments	Cardiovascular	Yes	No	Comments
Headaches				Chest pain			
Numbness				Palpitations			
Weakness							
Blurred vision							
Double vision							

Respiratory	Yes	No	Comments	Gastrointestinal	Yes	No	Comments
Persistent Cough				Nausea			
Shortness of breath				Vomiting			
Wheezing				Diarrhea			
				Blood in stool			

Genitourinary	Yes	No	Comments	Musculoskeletal	Yes	No	Comments
Frequent urination				Joint pain			
Nocturnal urination				Joint Swelling			
Painful urination				Limited mobility			

Integumentary	Yes	No	Comments	Psychiatric	Yes	No	Comments
Changing of mole				Abnormal mood			
Itchy skin				Insomnia			
Dry Skin				Anxiety			
				Sadness			

General	Yes	No	Comments
Fever			
Weight loss			
Night sweats			
Fatigue			

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Allergy Questionnaire - Intake Questions

Date:_____

Patient Name:_____ Date of Birth:_____

Reviewed by: _____

1. Do you experience symptoms of allergies? ☐ Yes ☐ No

2. Do you experience any of these symptoms more than twice per year: ☐ Yes ☐ No

   Cough, Nasal Congestion, Difficulty Breathing, Headaches, Wheezing, Runny Nose, Sore Throat, Itchy/Irritated Eyes, Ear Pain, Unexplained Fatigue, Skin Irritation or Snoring?

3. Have you ever been diagnosed with asthma or bronchitis? ☐ Yes ☐ No

4. Regarding possible food allergies, do you experience any of the following (please check all that apply):

   - ☐ Bloating after eating
   - ☐ Diarrhea
   - ☐ Constipation
   - ☐ Stomach Pain
   - ☐ Upset Stomach
   - ☐ Indigestion
   - ☐ Nausea
   - ☐ Vomiting
   - ☐ Tingling of the mouth or other unusual sensation

5. Are you interested in learning more about our allergy testing? ☐ Yes ☐ No

6. If you answered yes to question 5, then do you have any of the following (please check all that apply):

   - ☐ History of Anaphylaxis
   - ☐ On a Beta Blocker
   - ☐ Uncontrolled Asthma
   - ☐ Currently Ill
   - ☐ Pregnant
   - ☐ Immune Compromised

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History and Physical

Patient Name: _____ **Date of Birth:** _____

Please check *all* that apply.

Social History:			
Tobacco:	☐ Never ☐ <1 pack per day ☐ Year Started:	☐ Former smoker ☐ 1 - 2 packs per day ☐ Year Quit:	☐ Currently smoke ☐ 3 or more packs per day
Alcohol:	☐ Never	☐ 0 - 2 drinks per day	☐ 3 or more drinks per day
Employment:	☐ Employed Occupation:	☐ Not employed	☐ Student

Family History:	Relationship	FAMILY ONLY	Relationship
☐ Asthma		☐ Sinusitis	
☐ Hearing loss		☐ Anesthesia problems	
☐ Bleeding disorder		☐ Meniere's disease	
☐ Thyroid goiter		☐ Stroke before 60	
☐ Thyroid		☐ Heart attack before 60	

Medical Problems (Illnesses):	PERSONAL ONLY
☐ High blood pressure	☐ Diabetes
☐ Atrial fibrillation	☐ Stroke
☐ Asthma	☐ Kidney failure
☐ Sleep apnea	☐ DVT
☐ Acid reflux	☐ HIV
☐ Heart attack (MI)	☐ Hepatitis B or C
☐ Coronary artery disease	☐ Other medical problems not listed:
☐ Bleeding disorder	
☐ COPD / chronic bronchitis	
☐ Cancer (please write in): _____	

Past Surgeries (operations):	
☐ Ear tubes	☐ Kidney transplant
☐ Septoplasty	☐ Mastoidectomy
☐ Tonsillectomy	☐ Sinus surgery
☐ Cardiac stents	☐ Thyroidectomy
☐ Skin cancer	☐ Gastric bypass or banding
☐ Tympanoplasty	☐ Other surgeries:
☐ Rhinoplasty	
☐ Adenoidectomy	
☐ Cardiac bypass	

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Current Medications

Date:_____

Patient Name:_____

Current Medications: (please include over the counter medications and supplements)

Name of Drug	Dosage (Strength)	Frequency (times per day)	What is the medication for?

Drug Allergies:

Name of Drug	Reaction

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Patient's Name: _____

Date of Birth: _____

PCP: _____

ATTENDING PHYSICIAN LIST

(Who are your doctors that you see)

Cardiologist:

Name : _____

Address : _____

_____

Phone: _____

Fax : _____

Pulmonologist:

Name :

_____

Address :

_____

_____

Phone:

_____

Fax : _____

Dermatologist:

Name :

_____

Address :

_____

_____

Phone:

_____

Fax : _____

Oncologist / Radiation Oncologist:

Name :

_____

Address :

_____

Phone:

_____

Fax : _____

Gastroenterologist:

Name :

_____

Address :

_____

Phone:

_____

Fax : _____

Neurologist:

Name :

_____

Address :

_____

Phone:

_____

Fax : _____