



EAR, NOSE & THROAT ASSOCIATES, P.C.

PATIENT REVIEW OF SYSTEMS

Name: Referring Physician:

Date Of Birth: Appointment Date: Preferred Pharmacy: Address/city:

History: Do/Did you smoke/chew tobacco? Never smoked Current every day smoker Current occasional smoker Former smoker Type: Cigarettes Cigars Pipe Smokeless

If current did you quit within the last 12 months? Yes No Date Quit: Age Started:

Patient Language: English Spanish French Creole Other Patient Race: American Indian Asian Black/African American Hawaiian White Other

Patient Ethnicity: Hispanic/Latino Not Hispanic/Latino Do you use alcohol? Yes No Rarely # of Drinks per day: per week: Drug use: Yes No Type: Frequency:

Occupation: Have you had exposure to dust, fumes, etc? Yes No Type of Work: Have you had a recent change in your home/work environment? Yes No

(new carpet, new home, new drapes, etc.explain):

Past Medical History: (list all past and current medical problems) 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Past Procedures/Surgeries/Hospitalization History: None Description: Description: Description: Description: Description:

If over age 50 have you had a colonoscopy to test for colon cancer? Yes No If yes, date: If female over age 40 have you had a mammogram to screen for breast cancer?: Yes No If yes, date:

Medications: (List all current and occasional medications and dosages) None 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Allergies: (List allergies to any medications, foods, x-ray dye, etc. - also list type of reaction) None 1. 2. 3. 4.

Family History: (Circle any conditions of any blood relative) None Adopted Which Relative? Allergy Diabetes Stroke Heart Attack Thyroid Disease Cancer High Blood Pressure Heart Disease Bleeding Disorder Hearing Loss Which Relative?

Review of Systems: (each line must have either a yes or no response) asthma heart failure heart attack COPD diabetes hepatitis high blood pressure Elevated cholesterol Patient Signature: short of breath easy bruising/bleeding seizures stroke headaches skin cancer stomach/digestive problems Kidney/bladder problems dizzy HIV depression/anxiety muscle/joint pain tuberculosis mitral valve prolapse vision Loss