MID-MICHIGAN EAR, NOSE & THROAT

PATIENT NAME:

DOBAGESEX PHARMACY NAME/ADDRESS: REASON FOR VISIT TODAY: REVIEW OF SYSTEMS - If you currently have any of the following please circle all that apply. GENERAL Appetite Loss Chills Fatigue Fever Weight Gain>10lbs. Weight Loss>10lb SKIN Cracked Lips Dryness Hair Loss Hives Itching New Lesions Excessive Sweating HEAD, EYES, EARS, NOSE & THROAT Deafness Decreased Hearing Ear Discharge Nosebleed	LAST		FIRST		MIDDLE INIT	IAL	
REASON FOR VISIT TODAY: REVIEW OF SYSTEMS - If you currently have any of the following please circle all that apply. GENERAL. Appetite Loss Chills Fatigue Fever Weight Gain>10lbs. Weight Loss>10lb Stills Fatigue Fever Weight Gain>10lbs. Weight Loss>10lb Still Still of the plant of the following please circle all that apply. Stills Fatigue Fever Weight Gain>10lbs. Weight Loss>10lb Still of the plant of the following please circle all that apply. Method Stills Fatigue Fever Weight Gain>10lbs. Weight Loss>10lb Still of the plant of the following please circle all that apply. Method Still of the plant of the pla							
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ALLERGIES: No Known Drug Allergies

LATEX	
Iodine/IVP Dye	
Drugs: (list type and re	action type)
Foods: (list type and re	action type)

MEDICATIONS

Please list all of your current medications, including over the counter medications, supplements, and prescriptions.

Medication	Dosage	Frequency	

MEDICAL HISTORY – Please include (past or present) and (circle all that apply)

	<u>u</u>		
Allergic Rhinitis	Anemia		
Arthritis	Asthma		
Bleeding disorder	Cancer	Date	Туре
Carotid Artery Stenosis	Chronic Ea	ar Infections	
Chronic Sinusitis	Congestive	e Heart Failure	
COPD/Emphysema	Cystic Fibr	rosis	
Depression	Diabetes N	Iellitus	
Glaucoma	Hearing Loss		
Heartburn	Heart Attack		
Heart Disease	Heart Murmur		
Heart Valve Insufficiency	Hypertensi	on/High Blood Pressure	
Hospitalizations – Date	Reason		
Injuries to Nose, Face and/or Head	(explain)_		
Kidney Problems	Peripheral	Vascular Disease	
Seizure Disorder	Sickle Cell	Disease	
Sleep Apnea	Stomach U	llcer or Duodenal Ulcer	
Stroke/CVA	Thyroid D	isease	
Thyroid Nodule	Tinnitus		
Vitamin D Deficiency	No Pertine	nt Past Medical History	
Other:			

<u>SURGICAL HISTORY - (Circle all that apply)</u>

Adenoidectomy	Angiop	oplasty					
Cardiac Pacemaker Ins	sertion	Cardiac Stent					
Defibrillator Implant		Ear Surgery	Туре				
Glossectomy/Tongue		Hysterectomy					
Laryngectomy/Voice I	Box	Mastoidectomy	Mastoidectomy				
Myringoplasty		Myringotomy					
Myringotomy with Tube Placement		Parathyroidectomy					
Reduction Facial Fract	ure	Reduction Nasal Fracture					
Reduction Orbital Frac	cture	Rhinoplasty					
Sinus Surgery		Spinal Fusion/N	Neck				
Thyroidectomy – Left		Thyroidectomy	– Right				
Thyroidectomy – Subtotal		Thyroidectomy – Total					
Tonsillectomy		Total Hip Replacement					
Tubal Ligation	Tympa	nostomy					
Valve Replacement		Abdominal/Gastrointestinal					
Other:							
SOCIAL HISTORY							
Alcohol Use	NO	YES	Quantity				
Illicit Drug Use NO	YES	Type & Quantity					
Tobacco Use	NO	YES Type & Quantity					
Have you been treated in the past for substance or alcohol abuse NO YES				YES			
Most recent primary occupation							
FAMILY HISTORY – Circle all that apply and list relationship							
Anesthetic Complications		Bleeding Disor	der Cancer Type	e			
Congenital Hearing Loss		Diabetes	Congenital	Congenital Hearing Loss			
Diabetes Mellitus		Heart Disease	Hypertensio	Hypertension/High BP			
Lung/Respiratory Disease		Stroke/CVA	Thyroid Pro	Thyroid Problems			
No Pertinent Family History		Family History Unknown					

DIAGNOSTIC STUDIES – Circle any of the following studies you have had

Allergy Testing	Bone Density Study					
Cardiovascular Stress Test	Coronary Angiogram					
EGD/Endoscopy	EKG					
PFT's/Breathing Tests	MRI Brain, Brainstem and/or Inner Ears					
MRI C-Spine	MRI Neck					
MRI Face and/or Orbits	CT Scan of E	CT Scan of Brain				
CT Scan of Chest	CT Scan of H	Iead				
CT Scan of Neck	CT Scan Sinu	15				
CT Scan of Temporal Bones	Ultrasound, I	Ultrasound, Doppler/Carotids				
Ultrasound, Thyroid	C-Spine X-R	C-Spine X-Ray				
Chest X-Ray	Sinus X-Ray	Sinus X-Ray				
Please bring relevant test results	and CD image	es to you	ır appointment if available.			
For females only						
Are you currently pregnant or possi	bly pregnant	NO	YES			
Are you currently breastfeeding		NO	YES			
For children only						
Any newborn/birth complications?		NO	YES			
If yes, explain:						
Birth Weight						
Gestational Age						
Pregnancy Complications	NO	YES	Describe			
Newborn Complications	NO	YES	Describe			
Newborn Hearing Screen	NO	YES	If yes - PASS FAIL			
Are immunizations up to date?	NO	YES				
