Austin Ear, Nose
& Throat Clinic
PEDIATRIC AND ADULT CARE

PATIENT NAME:_____ _____ BIRTH DATE: _____ AGE:_____

REASON FOR TODAY'S VISIT/CHIEF COMPLAINT: _____

PREVIOUS TREATMENT FOR THIS PROBLEM?_____

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (check all that apply)

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Heart attack/arterial disease
- ☐ Other heart issue:
- ☐ **Problems with anesthesia**
- ☐ **Bleeding problems**
- ☐ Cancer(s), type(s) and date of diagnosis: _____

- ☐ Asthma
- ☐ Stroke
- ☐ Heartburn/reflux/hiatal hernia
- ☐ Anemia
- ☐ Thyroid problems

- ☐ Kidney disease
- ☐ Hepatitis
- ☐ HIV
- ☐ Tuberculosis
- ☐ Cholesterol issues

LIST OTHER PAST & CURRENT MEDICAL ISSUES

_____ _____ _____

_____ _____ _____

_____ _____ _____

LIST SURGERIES AND DATES

_____ _____ _____

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS AND DOSES (include supplements and any over the counter medications)

Do you take Asprin? ___NO___YES Dose #_____ mg/day

_____ _____ _____

_____ _____ _____

_____ _____ _____

LIST DRUG ALLERGIES AND REACTIONS: ☐ **NO KNOWN DRUG ALLERGIES**

_____ _____ _____

_____ _____ _____

TOBACCO USE: ___ **Never** ___**Yes** **Cigarettes** # _____ packs per day for _____years **Smokeless tobacco** # _____ years

___**Quit** ____yrs/mos ago. Previously #_____ packs per day for _____years

ALCOHOL USE: ___ **Never** Drinks #_____per week No alcohol for _____ months/years

CAFFEINE USE: ___ **None**___**Yes** How Much? #_____ caffeinated drinks most days

FAMILY MEDICAL HISTORY

Any family members with life-threatening reaction to anesthesia? _____

Mother: ___ Alive Died age _____ Significant Medical Problems _____

Father: ___ Alive Died age _____ Significant Medical Problems _____

Siblings: ____# sisters /____ # brothers Significant Medical Problems _____

Children: ____# girls / ____# boys Significant Medical Problems _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

Y	N	
___	___	Blurred vision
		Hearing loss
		Sinus issues
		Sore throat
		Ringing in ears/Tinnitus
		Hoarseness
		Chest Pain
		Irregular Heartbeat
		Heart problems/heart attack/surgery

Y	N	
		Shortness of Breath
		Snoring
		Heartburn
		Painful urination
		Joint pain
		Chronic sores
		Facial weakness
		Arm/leg numbness or weakness
		Anxiety

Y	N	
___	___	Fatigue
		Easy brusing
		Easy bleeding
		Allergies
		Fever
		Night sweats
		Unexpected weight loss

Can you walk a mile without stopping? ___YES___NO – Why not? ☐ joint pain ☐ shortness of breath ☐ other: _____

FOR OFFICE USE Reviewed by _____