Austin Ear, Nose & Throat Clinic

4315 James Casey St., Ste. 300 • Austin, TX 78745
Phone (512) 444-7944 • Fax (512) 444-7946

Name: ___________________________ Age: _______ Date of Birth: _____/_____/_______ Date: _______________

What medications are you allergic to? ____
What problem are you here to see the doctor about? ____
____
____
How long have the symptoms been present? ____
____
What operations have you had? ____
____
____
____

DO YOU OR HAVE YOU EVER HAD: (Check all that Apply)

Yes	No	
_____	_____	Heart Attack
_____	_____	Heart Surgery
_____	_____	Heart Arrhythmia
_____	_____	High Blood Pressure
_____	_____	Asthma
_____	_____	Emphysema
_____	_____	Cancer
_____	_____	Diabetes / High Blood Sugar
_____	_____	Anemia
_____	_____	HIV/AIDS
_____	_____	Sleep Apnea
_____	_____	Stroke
_____	_____	Hepatitis/Liver Disease
_____	_____	Thyroid Problems
_____	_____	Kidney problems/Dialysis

DO YOU REGULARLY HAVE: (Check all that Apply)

Yes	No	
_____	_____	Chest Pain
_____	_____	Shortness of Breath
_____	_____	Nausea
_____	_____	Vomiting
_____	_____	Diarrhea
_____	_____	Constipation
_____	_____	Reflux
_____	_____	Stomach Ulcers
_____	_____	Unexplained Weight Loss
_____	_____	Severe Anxiety/Depression requiring treatment
_____	_____	Muscle/Joint Pain
_____	_____	Fainting Episodes
_____	_____	Fever/Night Sweats
_____	_____	Leg weakness or numbness
_____	_____	Bleeding Problems/Thin Blood

What medications do you take? ____
____
Do you take aspirin? ___________ How were you referred here? ____
Are your vaccinations up to date? ____
Have you ever used tobacco? ____
Type of tobacco: ___________________________
How much per day? _________________________ How many years? _________________________
Quit (years ago) ____________________________ Live with a smoker? ________________________
Do you drink alcohol? ________________________ How much per day? ________________________

Office Use Only

Ht ______________ Wt______________ BP________________ Pulse_______________ Temp_______________

Austin Ear, Nose & Throat Clinic

4315 James Casey St., Ste. 300 • Austin, TX 78745
Phone (512) 444-7944 • Fax (512) 444-7946

ENT Review of Systems

Patient Name: ___________________________________ DOB: ____ /____ /____ Date: _________________

Are you currently having the following problems?

	YES	NO
EARS		
Hearing Loss?	_______	_______
Ringing or noises?	_______	_______
Drainage?	_______	_______
Earache or pain?	_______	_______
Itching?	_______	_______
Dizziness or balance problems?	_______	_______
NOSE/SINUS		
Treated with antibiotics for sinus infections?	_______	_______
Nasal stuffiness or obstruction?	_______	_______
Allergies?	_______	_______
Headache, facial pain or pressure?	_______	_______
Drainage down the back of throat?	_______	_______
Runny nose?	_______	_______
Loss or change of sense of smell?	_______	_______
MOUTH/THROAT/NECK		
Heartburn?	_______	_______
Acid or sour taste in throat?	_______	_______
Hoarseness or voice change?	_______	_______
Are you a singer?	_______	_______
Treated with antibiotics for throat infections?	_______	_______
Pain or difficulty swallowing?	_______	_______
Sore/s in mouth?	_______	_______
Lump in neck or face?	_______	_______
APNEA		
Do you have or have you been told you…		
Snore loudly?	_______	_______
Struggle to breathe at night?	_______	_______