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Head and Neck Surgery

EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

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Hearing Aids

Name _____ DOB _____ Age _____ Sex ☐ M ☐ F
Date _____ Height _____ Weight _____ Chart# _____

1) Describe the **major reason** for today's visit: _____
_____
_____
_____

How long has this been present? _____ Days _____ weeks _____ months _____ years
Any previous episodes? □ Yes □ No When: _____
Prior treatment? □ Over-the-counter medicines: _____
□ Prescription medicines: _____
□ Previous doctors visited: _____

2) Is there a **second problem** you would like evaluated? _____
_____
_____

Any previous episodes? □ Yes □ No When: _____
Prior treatment? □ Over-the-counter medicines: _____
□ Prescription medicines: _____
□ Previous doctors visited: _____

3) Illnesses: Do you have or have you ever had any of the following? Please check all that apply.

□ Chronic lung disease
□ Asthma
□ Recent Pneumonia
□ Diabetes: □ Type I □ Type II
□ Kidney Disease
□ High Blood Pressure
□ Previous Stroke
□ Gastric Ulcers
□ Migraine Headaches
□ Allergies
□ Chronic Ear Infections
□ Chronic Sinusitis
□ Thyroid Disease
□ Arthritis
□ Recent Dental Issues
□ HIV
□ Seizure Disorder
Specify_____
□ Anesthesia Reaction
Specify_____
□ Bleeding Disorder
Specify_____
□ Cancer
Specify_____
□ Heart Disease or heart attack
Specify_____
□ Hepatitis
Specify_____
□ Other
Specify_____
_____
_____

Any significant or recent hospitalizations? □ Yes □ No
Please explain: _____

_____

4) Surgeries: Have you ever had any of these surgeries? Please check all that apply and, if possible, give the date (month and/or year).

□ Tonsillectomy
□ Adenoidectomy
□ Ear Tubes
□ Septoplasty
□ Thyroidectomy
□ Cholecystectomy
□ Appendectomy
□ Hysterectomy
□ Prostatectomy
□ Hemorrhoidectomy
□ Hernia Repair

□ Other Throat Surgery
Specify_____
□ Neck Surgery
Specify_____
□ Other Ear Surgery
Specify_____
□ Previous Sinus Surgery
Specify_____
□ Cardiac Procedures
Specify_____
_____
_____

Please list any other surgeries: _____

_____

5) Medications: Please list prescription medications being taken.

Medication	Strength	How many times per day?

Please list over-the-counter medication being taken.

Medication	Strength	How many times per day?

Do you take prescription blood thinners, aspirin or fish oil? □ Yes □ No
Specify _____

6) Allergies: Allergies to medications

Penicillin □ Yes □ No Reaction: _____
Codeine □ Yes □ No Reaction: _____
Sulfa □ Yes □ No Reaction: _____
Other: _____ Reaction: _____
Other: _____ Reaction: _____
Other: _____ Reaction: _____

Allergies to medical products like tape, iodine, or latex? □ Yes □ No
Specify: _____ Reaction: _____

7) Social History:

Does your religion prohibit you from receiving blood products or blood transfusions? □ Yes □ No
**If yes, please be sure to discuss this with the doctor at the time of your evaluation.*

Occupation: _____
Exposure to loud noises? □ Yes □ No Specify: _____

Smokers in the home? □ Yes □ No If yes: □ Smokes Inside □ Smokes Outside
Do you or have you ever smoked? □ Yes □ No
□ 10/day □ 20/day □ 30/day □ 40/day If more please specify: _____/day
Age you started: _____ Age you quit: _____

Do you drink alcohol? □ Currently □ Socially □ Occasionally □ Rare □ Never

Recreational drug use? □ Never □ Previously □ Currently, specify _____

8) Review of Systems: Please check any of the following symptoms you *currently* have.

Ears	**Nose**	**Throat**	**Other**
□ Hearing loss	□ Difficulty breathing	□ Sore throat	□ Shortness of breath
□ Ringing in ear	□ Allergies	□ Acid Reflux	□ Persistent Cough
□ Dizziness/vertigo	□ Sinus drainage	□ Snoring	□ Bloody sputum
□ Ear drainage	□ Nose bleeds	□ Apnea	□ Wheezing
□ Ear infections	□ Headaches	□ Difficulty Swallowing	□ Chest pain
□ Ear pain	□ Injury	□ Painful Swallowing	□ Heart Palpitations
□ Hole in eardrum	□ Sinusitis	□ Hoarseness	□ Ankle swelling
□ Speech delay	□ Congestion	□ Neck masses/nodes	□ Stomach pain
		□ Thyroid problems	□ Fever
			□ Problems with urination or bowel movements

9) Family History: Please report significant family medical history in this section.

History:	**Specify Family Member (i.e. maternal grandmother, paternal uncle):**
□ Anesthesia Reactions	_____
□ Birth Defects (specify type)	_____
□ Bleeding/Clotting Problems	_____
□ Cancer (specify type)	_____
□ Diabetes (specify type)	_____
□ Hearing Loss	_____
□ Heart disease	_____
□ Thyroid disease	_____