EAR, NOSE AND THROAT SPECIALISTS OF MIDDLETOWN, INC.

Date: _____

Name: _____ Birth date: _____ AGE: _____

Height :_____ Weight : _____

DO YOU HAVE PROBLEMS WITH:

	Yes	No	BRIEF DESCRIPTION
Ears	☐	☐	_____
Hearing	☐	☐	_____
Throat	☐	☐	_____
Nasal	☐	☐	_____
Heart	☐	☐	_____
Blood Pressure	☐	☐	_____
Lungs	☐	☐	_____
Breathing	☐	☐	_____
Thyroid or Endocrine	☐	☐	_____
Prostate	☐	☐	_____
Gastrointestinal	☐	☐	_____
Swallowing	☐	☐	_____
Facial Skin Lesions	☐	☐	_____
Allergies (Drug and Environmental)	☐	☐	_____
Diabetes	☐	☐	_____
Have You Had Surgery	☐	☐	_____
Exposure to Dust/Fumes	☐	☐	_____
Dizziness	☐	☐	_____
Tinnitus (ear noise)	☐	☐	_____
Noise Exposure	☐	☐	_____
Other	☐	☐	_____

Occupation: _____

GO TO PAGE 2

HAS ANYONE IN YOUR FAMILY HAD: **FAMILY HISTORY**

	Yes	No	WHO
Blood Pressure Problems	☐	☐	_____
Heart Disease	☐	☐	_____
Hearing Loss	☐	☐	_____
Cancer 0	☐	☐	_____
Diabetes	☐	☐	_____
Cholesterol/Triglycerides	☐	☐	_____
Other	☐	☐	_____
			_____

SOCIAL HISTORY:

☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of Children at Home: _____

Live Alone: ☐ Yes ☐ No

Living Where: ☐ Home ☐ Apartment ☐ Nursing Home ☐ Other: _____

Family Doctor: _____

	Yes	No	Frequency of Use	QUIT? When?
Tobacco Use	☐	☐	_____	_____
Alcohol Use	☐	☐	_____	_____
Recreational Drug Use	☐	☐	_____	_____

Known Drug Allergies : _____

_____

Current Medications: Include ALL Over the Counter Medications, Herbal remedies, vitamins or supplements

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____