Name:_____
DOB: _____/_____/_____
Email:_____
Primary Dr._____
Referring Dr:_____

What brings you to the office today?
NEW **ANNUAL**
Reason:_____
_____

Have you had any testing regarding the reason for you visit today? YES NO___
Where?_____

Allergies & Reactions:
_____
_____
_____

Prescription and OTC Medications
Vitamins & Supplements :
_____
_____
_____
_____
_____

Surgical History:
Name of Surgery & Date
_____
_____
_____
_____

Anesthesia Complications: YES NO
If so, please explain:_____

Social History:
Have You Ever Used Tobacco? YES NO
Do You Currently Use Tobacco? YES NO
If quit, when did you quit? _____
Packs Per Day: _____ # of Years ____
Do you drink alcohol? YES NO
How Frequently? _____

Occupational/Military History:
_____

Check all that apply to YOU & explain:

Diabetes: Type 1 or Type 2	
Cancer: Type	
Heart Problems:	
High Blood Pressure:	
High Cholesterol:	
Bleeding Disorders:	
Stroke or TIA: if so, please circle one	
Sleep Apnea: CPAP: YES NO	
Asthma: Last Attack / /	
Thyroid Disease:	
COPD:	
GERD/ Reflux:	
Kidney Disease:	
Liver Disease:	
Assistive Devices: Cane/Walker/Wheel Chair	
Vision: Glasses or Contacts	
Hearing Aids: right left both	
Other Medical Conditions:	

Weight:_____ Height:_____

Family History:

Member	Age/ Gender	Medical Problem(s)
Father		
Mother		
Sibling(s)		

Has anyone in your FAMILY had:
Hearing Loss at Young Age YES NO
Ear Surgery YES NO
Birth Defects YES NO
Anesthesia Complications YES NO
Bleeding Disorder YES NO
Thyroid Disease YES NO

Ear, Nose & Throat Care of WNY
Patient Review of Systems

Please check any of the following problems that YOU have had in the past 3-6 months.

Name: _____ Date:____/____/____

General Health
- ☐ Severe Fatigue
- ☐ Night Sweats(Daily)
- ☐ Fever Over 101*
- ☐ Significant Weight Gain/ Loss

Eyes & Vision
- ☐ Eye Pain
- ☐ Visual Changes

Ears
- ☐ Ache Right Left
- ☐ Infection Right Left
- ☐ Drainage Right Left
- ☐ Itching Right Left
- ☐ Ringing Right Left
- ☐ Plugged Right Left

Nose & Sinus
- ☐ Nasal Obstruction
- ☐ Mouth Breathing
- ☐ Snoring
- ☐ Loss of Smell
- ☐ Runny Nose
- ☐ Daily Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Pain
- ☐ Sinus Headache
- ☐ Sinus Infection

Mouth & Throat
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Feeling of Something Stuck In Throat
- ☐ Throat Clearing
- ☐ Hoarse Voice

Cardiovascular
- ☐ Irregular Heartbeat
- ☐ Blacking Out

Lung & Respiratory
- ☐ Cough

Gastrointestinal
- ☐ GERD/Reflux
- ☐ Heartburn

Skin
- ☐ Lesions

Neurological
- ☐ Balance Problems
- ☐ Dizziness/ Vertigo
- ☐ Headaches(Frontal)

Endocrine
- ☐ Diabetes
- ☐ Goiter/ Thyroid

Blood & Lymph
- ☐ Excessive Bleeding
- ☐ Anemia
- ☐ Bruising Easily
- ☐ Swollen Glands

Allergies
- ☐ Hay Fever
- ☐ Asthma

Head & Neck
- ☐ Neck Masses
- ☐ Injuries

Pharmacy Information:

Local:

Name:_____

Address:_____

Phone:_____

30 or 90 day supply

Mail Order:

Name:_____

90 day supply