Parker Ear, Nose and Throat
148 East Avenue
Norwalk, CT 06851
(203) EAR-NOSE or (203) 866-8121

Patient Medical History

Date:

Patient Name:	Account #:	DOB:	Age:
Address:			
City:	State:	Zip Code:	
What problems are you here for today?	List any ALLERGIES to MEDICATIONS:		

Past Medical History

Please check "Yes" or "No" to indicate if you have any of the following illnesses; for "Yes" answers, please explain.

Illness	Yes	No	Explain	Illness	Yes	No	Explain
Diabetes	☐	☐		Stomach or intestinal problems	☐	☐	
Hypertension (high blood pressure)	☐	☐		Allergy problems/Therapy	☐	☐	
Thyroid Problems	☐	☐		Kidney Problems	☐	☐	
Heart Disease/Cholesterol Problems	☐	☐		Neurological problems	☐	☐	
Respiratory Problems	☐	☐		Cancer	☐	☐	
Bleeding Disorder	☐	☐		Other Medical Diagnosis	☐	☐	

Please list any operations you have had and dates performed (including tonsils & adenoids): _____

_____

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Please list any current medications (include amounts and times per day). Please include aspirin, antacids, vitamins, hormone replacement, birth control, herbal suppliments, OTC Nasal sprays, and medication for colds, allergies and sinus. _____

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Review of Systems

Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms
For any "Yes" responses, please check the "Current" box if this symptom relates to your visit today

Body System	Symptom	Yes	No	Current	Symptom	Yes	No	Current
General	Chills	☐	☐	☐	Weight Loss or Gain	☐	☐	☐
	Fatigue	☐	☐	☐	Daytime sleepiness	☐	☐	☐
Allergy	Environmental allergy	☐	☐	☐	Sneezing fits	☐	☐	☐
	Post-nasal drip	☐	☐	☐				
Neuro	Headache	☐	☐	☐	Weakness	☐	☐	☐
	Passing out	☐	☐	☐	Numbness, tingling	☐	☐	☐
Eyes	Eye pain / pressure	☐	☐	☐	Vision changes	☐	☐	☐
	Watery or itchy eyes	☐	☐	☐				
ENT	Ear pain or itch	☐	☐	☐	Ear drainage	☐	☐	☐
	Hearing loss	☐	☐	☐	Ear noises	☐	☐	☐
	Dizziness	☐	☐	☐	Lightheadedness	☐	☐	☐
	Nasal congestion	☐	☐	☐	Sinus pressure or pain	☐	☐	☐
	Sense of smell problem	☐	☐	☐	Problem snoring, apnea	☐	☐	☐
	Hoarseness	☐	☐	☐	Throat pain	☐	☐	☐
	Throat clearing	☐	☐	☐	Throat dryness / itching	☐	☐	☐
Respritory	Cough	☐	☐	☐	Coughing blood	☐	☐	☐
	Wheezzing	☐	☐	☐	Shortness of breath	☐	☐	☐
Cardiac	Chest pain	☐	☐	☐	Palpitations	☐	☐	☐
GI	Difficulty swallowing	☐	☐	☐	Heartburn	☐	☐	☐
	Abdominal pain	☐	☐	☐	Nausea / vomitting	☐	☐	☐
	Bowel irregularity	☐	☐	☐	Rectal bleeding	☐	☐	☐
GU	Frequent urination	☐	☐	☐	Prostate problems	☐	☐	☐
Heme/lymph	Swollen glands	☐	☐	☐	Sweating at night	☐	☐	☐
	Bleeding problems	☐	☐	☐	Easy bruising	☐	☐	☐
Endo	Feel warmer than others	☐	☐	☐	Feel cooler than others	☐	☐	☐
MSK	Joint aches	☐	☐	☐	Muscle aches	☐	☐	☐
Skin	Rash	☐	☐	☐	Hives	☐	☐	☐
	Itching	☐	☐	☐	Skin or hair changes	☐	☐	☐

Reviewed By:_____

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Patient Name: Acct Number: DOB:

Social History

	Yes	No	Details:
Do you smoke? How much?	☐	☐	
If no, did you smoke previously?	☐	☐	
How often do you drink alcohol?			
What type of alcohol do you prefer?			
How much caffeine do you consume per day?	Coffee ____ cups, Decaf ____ cups, Tea ____ cups, Soda ____ glasses, Chocolate ____ oz.		
How much mint, cinnamon &/or ginger (circle which) do you consume per day?	Gum ____ sticks, Candy ____oz., Throat lozenges ____ oz.		
What is your occupation?			

Family History

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses; if "Yes", please indicate which relative(s) have the illness:

Illness	Yes	No	Explain
Hearing problems	☐	☐	
Allergy	☐	☐	
Cancer	☐	☐	
Bleeding Disorder	☐	☐	
Anesthesia Problems	☐	☐	

Doctors Notes: _____

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Reviewed By:_____