Welcome to ENT of Georgia. Our goal is to provide you and your family with the highest of care. The first step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete all pages of the form below. Our staff would be glad to help you if necessary. The care we give can be no better than the information you provide.

Name_____ Age: _____ Date of Birth: _____

Who sent to us today? _____
This person is: ___ Primary physician
___ Other Physician
___ Non-physician health care provider
___ Friend/Other

Gender ___ Male ____ Female

Primary Physician (Name & Phone Number)

_____

_____

Please name the major problem or symptom that brings to us today:

_____

Rate the severity of today's symptoms on a 1-10 scale (10 = worst) _____

How long have your symptoms been present? _____

What makes your symptoms worst or better? _____

What other providers have you seen for this illness? _____

What diagnostic tests have been performed so far? _____

Please check those symptoms below which apply to you:

__Severe headache	__Facial pain	__Nosebleed	__Ear drainage	__Cough
__Failing vision	__Nasal discharge	__Loss of smell/taste	__Dizzy/off balance	__Hoarseness
__Eye pain	__Post-nasal drip	__Hearing loss	__Ear fullness/pressure	__Heartburn
__Double vision	__Frequent sneezing	__Ringing in ears	__Difficulty swallowing	__Neck mass/swollen glands
__Nasal congestion	__Nasal obstruction	__Ear pain	__Can't clear throat	__Snoring
				__Stop breathing during sleep
				__Sleepy in the daytime

Review of Systems

Please check those symptoms below which apply to you:

__Fever/Chills	__Shortness of breath	__Painful urination	__Itchy Skin	__Heat tolerance
__Weight loss	__Wheezing	__Weak urine system	__Weakness	__Frequent thirst
__Night sweats	__Cough up blood	__Blood in urine	__Shaking/tremor	__Anemia
__Light bothers eyes	__Abdominal pain	__Painful/swollen joints	__Fainting	__Bruise easily
__Irritated eyes	__Nausea/Vomiting	__Back pain	__High Stress	__Prolonged bleeding
__Eyes crust/drain	__Yellow Jaundice	__Rash	__Depression	__HIV Risk Factors
__Chest pain	__Bloody stool	__Hair/Nail problem	__Mood Swings	
__Irregular heartbeat	__Diarrhea	__Flaking/peeling skin	__Cold tolerance	

Past Medical History

Please check those symptoms below which apply to you:

__Glaucoma	__Have pacemaker	__Hepatitis A	__Meningitis	__Food allergy
__Cataract	__Prior angioplasty	__Hepatitis B	__Mental health problems	__Contact allergy
__Macular degeneration	__Obstructive sleep apnea	__Hepatitis C	__HIV positive	__Tape allergy
__High blood pressure	__Asthma	__Fibromyalgia	__Low thyroid	__ Latex allergy
__Past heart attack	__COPD/emphysema	__Gout	__Overactive thyroid	__ Inhalant allergy
__Prior Stroke	__Tuberculosis	__Arthritis	__Thyroid nodule	__ Previous skin test
__Blocked arteries	__Pneumonia	__Seizure disorder	__Thyroid cancer	__ Bleeding disorder
__Heart failure	__Use of oxygen at home	__Parkinson's disease	__Diabetes-diet control	__ Use aspirin
__Mitral valve prolapse	__Reflux	__Spinal injury	__Diabetes-oral meds	__Use Coumadin
__Past bypass surgery	__Hiatal hernia	__Head injury	__Diabetes-insulin	__ Use Plavix
				__ Use nonsteroidal antiflammatiom
				__ Use other blood thinner

Surgical History

Please list all prior surgical procedures

Operation	Date	Operation	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications you TAKE
Include vitamins, supplements, herbals
☐ **I consent to ALL Electronic Prescription Transactions**

Drug Name: **Dosage:**

_____ _____

_____ _____

_____ _____

_____ _____

Medications/Food ALLERGY
List allergies and bad reactions to medications
Latex Allergy ☐ **YES** ☐ **NO**

Drug/ Food Name: **Reaction:**

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy Name and Phone Number: _____

Family History
Please check those illnesses that are present in your immediate blood relatives (parents, children, siblings):

___Heart attack/ disease
___Blocked arteries in legs
___Stroke
___Allergies
___High blood pressure
___Diabetes
___Thyroid problems
___Cancer
___Hearing loss
___Sickle cell/trait
___Bleeding problem
___Asthma

Social History
What type of work/school do you do? _____

Who lives with you at home? _____

Do you smoke?

☐ Yes, _____ packs of cigarettes per day

☐ Quit ____ years ago, smoke ____ packs per day

☐ Never

Are you exposed to second smoke? ☐ Yes ☐ No

You consume ____ alcoholic beverages per day/week/month (circle)

You consume ____ caffeine beverages per day (coffee, tea, ice tea, mountain dew, etc)

You consume ____ glasses of water per day

Is there any chance you may be pregnant? ☐ Yes ☐ No ☐ N/A

Have you had a pneumonia vaccination? ☐ Yes ☐ No Date: _____

Have you had Flu vaccination? ☐ Yes ☐ No Date: _____

Are you exposed to cats? ☐ Yes ☐ No

Are you exposed to dogs? ☐ Yes ☐ No

Height _____ Weight _____

_____ _____
Patient Signature Date