ctENT
Sinus Center | Hearing & Balance

Patient Name:______________________________ DOB: ____________

Date:______________________ Age: ____________ **Email:** ______________________________

What problems are you here for TODAY?

1. ______________________
2. ______________________
3. ______________________

Allergies to Medication or Latex

____

____

____

Past Medical History

☐ None

☐ Cancer: ____________________

☐ Cardio: Atrial Fibrillation

☐ Cardio: Hypertension/High Blood Pressure

☐ Cardio: Myocardial Infarction/Heart Attack

☐ Cardio Other: ____________________

☐ Endocrine: Diabetes Type I or Type II

☐ GI: Reflux/GERD

☐ Immuno: Immunodeficiency/HIV

☐ Lymph: Anemia/Bleeding disorder/Clotting

☐ Lymph Other: ____________________

☐ Neuro: Headache/migraines

☐ Neuro Other: ____________________

☐ Ophth/opt: Blindness/Macular degeneration/Cataracts/Glaucoma

☐ Ophth/opt Other: ____________________

☐ Psych: Anxiety/Depression/other: ____________________

☐ Pulm: Asthma/COPD/Sleep Apnea/Pulmonary Embolism

☐ Pulmonary Other: ____________________

☐ Rheum: Autoimmune Disorder (specify type) ____________________

☐ Vascular: Carotid Stenosis

☐ Vascular Other: ____________________

Surgical History

Please list any operations you have ever had:

☐ None ____

____

____

ENT Medical History

☐ None

☐ Cancer: Head or Neck: ____________________

☐ Ear: Acoustic Neuroma/Cholesteatoma/Hearing Loss

☐ Ear: Mastoiditis

☐ Ear: Other ____________________

☐ Ear: Vertigo

- ☐ General: Reflux
- ☐ Larynx: ______________________________
- ☐ Nasal: Deviated Septum
- ☐ Nasal: Epistaxis (nose bleed)
- ☐ Nasal: Loss of Smell
- ☐ Nasal: Nasal Fracture
- ☐ Nasal: Nasal Obstruction
- ☐ Nasal: Polyps
- ☐ Nasal: Rhinitis (allergies)
- ☐ Nasal: Sinusitis
- ☐ Neck: Neck Mass
- ☐ Neck: Other ______________________________
- ☐ Neck: Thyroid Nodules
- ☐ Oral: Sleep Apnea

ENT Surgery

- ☐ None
- ☐ Ear: Mastoidectomy
- ☐ Ear: Myringotomy
- ☐ Ear: Other ______________________________
- ☐ Head & Neck: ______________________________(specify)
- ☐ Nose: Balloon Sinuplasty
- ☐ Nose: Endoscopic Sinus Surgery
- ☐ Nose: Nasal Fracture Repair
- ☐ Nose: Balloon Sinuplasty
- ☐ Nose: Rhinoplasty
- ☐ Nose: Septoplasty
- ☐ Nose: Turbinate Reduction
- ☐ Throat: Adenoidectomy
- ☐ Throat: Sleep Apnea
- ☐ Throat: Tonsillectomy
- ☐ Other: ______________________________

ENT Family History

☐ None ☐ Hearing Loss ☐ Sinusitis ☐ Thyroid Cancer ☐ Other: ______________________________

ENT Pediatric History

☐ None ☐ Cleft Palate ☐ Otitis Media ☐ Other: ______________________________

Medications

(Please list ALL medication you are CURRENTLY taking)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Social History: Former Smoker/Never Smoked/Current everyday/Current Someday **Occupation:**____________________

Primary Care doctor:_______________________________________

Referring Physician: _______________________________________

Patient Name:____ DOB: ___/___/______

ALERTS

☐ None

☐ Patient does not speak English

☐ Allergy to latex

☐ Blood Thinner

☐ Joint Replacement/Spinal Hardware

☐ Pacemaker

☐ HIV Positive

☐ Hepatitis C Positive

☐ Other: ______________________________

Review of Symptoms

Please Check the "yes" box to indicate whether you CURRENTLY have any of following symptoms:

	YES		YES
☐ Bleeding	☐	☐ Vision Loss	☐
☐ Dizziness	☐	☐ Heartburn	☐
☐ Ears, Itching	☐	☐ Vomiting	☐
☐ Hearing Loss	☐	☐ Hematuria **(blood in urine)**	☐
☐ Hoarseness	☐	☐ Bruising	☐
☐ Nasal Obstruction	☐	☐ Blisters	☐
☐ Throat Pain	☐	☐ Rash	☐
☐ Tinnitus (ringing in ears)	☐	☐ Swelling	☐
☐ Exercise Intolerance	☐	☐ Headache	☐
☐ Fatigue	☐	☐ Memory Loss	☐
☐ Night Sweats	☐	☐ Anxiety	☐
☐ Dry Skin	☐	☐ Depression	☐
☐ Moist Skin	☐	☐ Cough	☐
☐ Double Vision	☐	☐ Shortness of Breath	☐
☐ Eye Pain	☐	☐ Wheezing	☐