THE EAR, NOSE & THROAT CENTER, AMC

Please list all medical history
(I.e., High B/P, Diabetes, Cancer)

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Please list all surgeries

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Please list all medications, including over the counter

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Allergies:

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Social History: Marital status _______ Education level _________
Employment ____
Tobacco __________ Alcohol _________ Drugs __________

Family History: Bleeding disorders ________ Diabetes _________
Heart disease ________ Cancer _________________________
Thyroid disorder ________ Other: ______________________

Have you ever tested positive to or been exposed to Tuberculosis (TB)? Yes ______ No ______

Please check (√) symptoms you have had within the past six weeks:

General		**Respiratory**		**Neurological**	
Fever/chills	_____	Cough	_____	Dizziness	_____
Weight loss/gain	_____	Wheezing	_____	Fainting	_____
Fatigue	_____	Noisy breathing	_____	Seizures	_____
Night sweats	_____	Short of breath	_____	Weakness	_____
		Snoring	_____		
Eyes				**Psychological**	
Change in vision	_____	**Cardiovascular**		Nervousness	_____
Double vision	_____	Chest pains	_____	Depression	_____
Glaucoma	_____	Palpitations	_____	Mood changes	_____
		Edema (swelling)	_____		
Ears, Nose, Mouth & Throat		Previous heart attack	_____	**Endocrine**	
Hearing loss	_____			Thyroid enlargement	_____
Ear pain/drainage	____	**Gastrointestinal**		Heat/cold intolerance	_____
Sinus problems	_____	Indigestion	_____		
Hoarseness	_____	Trouble swallowing	_____	**Hematology/Lymph**	
		Nausea/vomiting	_____	Anemia	_____
Allergic		Ulcers	_____	Blood clots	_____
Nasal obstruction	_____	Blood in stool	_____	Jaundice	_____
Itching	_____			Easy-bruising	_____
Unusual infection	_____	**Musculoskeletal**		Enlarged lymph nodes	_____
		Muscle aches	_____		
Genito-Urinary		Joint stiffness	_____	______________________	
Pain on urination	_____	Broken bones	_____		
Frequent urination	_____			______________________	
Kidney stones	_____	**Skin/Breast**			
		Rashes	_____	______________________	
Other ____________________		Abnormal hair/nail growth	_____	______________________	
___________________________		Breast lumps/discharge	_____		

NAME: ______________________________ **DOB:** ______________ **DATE:** __________________