Wasatch Ear, Nose, Throat & Allergy

M. Scott Major, M.D. / Sean Carver, PA-C / Lisa Byrd, PA-C Today's Date: ____/____/____

Name: _____ Date of Birth: ____/____/____

Referring Physician / Family Physician: _____

Purpose of Visit: _____

Weight: _____ **Height:** _____

Are you allergic to any medications? ❒ No ❒ Yes – Please List _____

Are you allergic to latex? ❒ No ❒ Yes

If you are a woman of menstruating age, are you pregnant? ❒ No ❒ Yes – Due Date: _____

Please list **all medications** you take on a regular basis, including **over-the-counter medicines**. ❒ None

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently smoke? ❒ No ❒ Yes – How many cigarettes per day? _____

Have you ever smoked? ❒ No ❒ Yes – How many years? _____ Quit Date: _____

Do you drink alcohol? ❒ No ❒ Yes – How many drinks per week? _____

Have you had your **tonsils** removed? ❒ No ❒ Yes – Year: _____

Have you had your **adenoids** removed? ❒ No ❒ Yes – Year: _____

Have you had **tubes** surgically placed in your ears? ❒ No ❒ Yes – Year(s): _____

Have you had a **deviated nasal septum** surgically repaired? ❒ No ❒ Yes – Year: _____

Have you had **sinus** surgery? ❒ No ❒ Yes – Year: _____

Have you had your **thyroid** removed? ❒ No ❒ Yes – Year: _____

Please list **any other surgeries** and the year they were performed. ❒ None

_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____

Please check any **medical illnesses** you have.

❒ None	❒ Crohn's Disease	❒ Multiple Sclerosis
❒ Diabetes	❒ Celiac Disease	❒ Parkinson's Disease
❒ Hypertension	❒ Depression	❒ Rheumatoid Arthritis
❒ Asthma	❒ Lupus	❒ Schizophrenia
❒ Cancer: _____	❒ Muscular Dystrophy	❒ Other: _____

Occupation: _____ ❒ Retired ❒ Not Employed

Parents name(s) if the patient is under 18 years of age: _____

Please fill out other side →→→

Please check if any of the following apply to you now, in the past, or frequently.

Constitutional
❒ Fatigue
❒ Fever
❒ Weight Gain
❒ Weight Loss

Eyes
❒ Vision Changes
❒ Dry Eyes
❒ Itchy Eyes
❒ Other: _____

Ears/Nose/Throat/Neck
❒ Sinus Problems
❒ Difficulty Swallowing
❒ Hearing Difficulty
❒ Ear Pain
❒ Nasal Drainage
❒ Sore Throat
❒ Ringing in Ears
❒ Other: _____

Cardiovascular
❒ Chest Pain
❒ Heart Palpitations
❒ Other: _____

Respiratory
❒ Frequent Cough
❒ Coughing up Blood
❒ Wheezing
❒ Shortness of Breath
❒ Other: _____

Gastrointestinal
❒ Nausea
❒ Vomiting
❒ Diarrhea
❒ Constipation
❒ Blood in Stool
❒ Heartburn
❒ Other: _____

Genitourinary/Nephrology
❒ Frequent Urination
❒ Leakage of Urine
❒ Blood in Urine
❒ Hot Flashes
❒ Other: _____

Musculoskeletal
❒ Arthritis
❒ Swelling of the Legs
❒ Muscle Weakness
❒ Other: _____

Dermatologic
❒ Rash
❒ Hives
❒ Eczema
❒ Generalized Itching
❒ Other: _____

Neurologic
❒ Headaches
❒ Dizziness
❒ Seizures
❒ Other: _____

Psychiatric
❒ Depression
❒ Anxiety
❒ Insomnia
❒ Other: _____

Endocrine
❒ Breast Lump
❒ Goiter
❒ Abnormal Periods
❒ Excessive Thirst
❒ Other: _____

Hematologic/Lymphatic
❒ Blood Transfusion
❒ Easy Bruising
❒ Easy Bleeding
❒ Lightheadedness
❒ Other: _____

Allergy/Immunology
❒ Asthma
❒ Facial Swelling
❒ Mouth/Throat Swelling
❒ Other: _____