

Wasatch Ear, Nose, Throat & Allergy

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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.

- | | | |
|----------------------------------------|---------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Depression | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lupus | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Other: _____ |

Occupation: _____ Retired Not Employed

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

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: _____