

# ANNAPOLIS ENT ASSOCIATES

NAME: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

## Past Medical History:

Please fill in if you had any of the following

- |                                 | YES                      |                                | YES                      |
|---------------------------------|--------------------------|--------------------------------|--------------------------|
| 1. Asthma                       | <input type="checkbox"/> | 9. Heart Attack/ Heart Disease | <input type="checkbox"/> |
| 2. Bleeding Disorders           | <input type="checkbox"/> | 10. High Blood Pressure        | <input type="checkbox"/> |
| 3. Cancer                       | <input type="checkbox"/> | 11. HIV                        | <input type="checkbox"/> |
| Lung                            | <input type="checkbox"/> | 12. Irregular Heart Beat       | <input type="checkbox"/> |
| Lymphoma                        | <input type="checkbox"/> | 13. Kidney Disease             | <input type="checkbox"/> |
| Head and Neck                   | <input type="checkbox"/> | 14. Liver Disease              | <input type="checkbox"/> |
| Thyroid                         | <input type="checkbox"/> | 15. Migraine Headaches         | <input type="checkbox"/> |
| 4. Cataracts                    | <input type="checkbox"/> | 16. Osteoporosis               | <input type="checkbox"/> |
| 5. Depression                   | <input type="checkbox"/> | 17. Pneumonia                  | <input type="checkbox"/> |
| 6. Diabetes                     | <input type="checkbox"/> | 18. Reflux/ Stomach Ulcers     | <input type="checkbox"/> |
| 7. Emphysema/Chronic Bronchitis | <input type="checkbox"/> | 19. Stroke                     | <input type="checkbox"/> |
| 8. Glaucoma                     | <input type="checkbox"/> | 20. Sleep apnea                | <input type="checkbox"/> |

## Surgical History:

Have you had any of the following?

- |                            | YES                      |   | YES                      |
|----------------------------|--------------------------|---|--------------------------|
| 1. Adenoid Removal         | <input type="checkbox"/> | 11. Gallbladder Removal                               | <input type="checkbox"/> |
| 2. Appendix Removal        | <input type="checkbox"/> | 12. Heart Artery Bypass,<br>Stent/Balloon Angioplasty | <input type="checkbox"/> |
| 3. Brain Surgery           | <input type="checkbox"/> | 13. Hernia Repair                                     | <input type="checkbox"/> |
| 4. Breast Surgery/Biopsy   | <input type="checkbox"/> | 14. Hysterectomy                                      | <input type="checkbox"/> |
| 5. C-Section               | <input type="checkbox"/> | 15. Lung Surgery                                      | <input type="checkbox"/> |
| 6. Carotid Surgery         | <input type="checkbox"/> | 16. Orthopedic Surgery                                | <input type="checkbox"/> |
| 7. Defibrillator/Pacemaker | <input type="checkbox"/> | 17. Sinus Surgery                                     | <input type="checkbox"/> |
| 8. Dental Extraction       | <input type="checkbox"/> | 18. Thyroid Surgery                                   | <input type="checkbox"/> |
| 9. Ear Tube Placement      | <input type="checkbox"/> | 19. Tonsil Removal                                    | <input type="checkbox"/> |
| 10. Eye Surgery            | <input type="checkbox"/> | 20. UPPP  | <input type="checkbox"/> |

## Medications:

Please list medications that you are currently taking

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Prescribed By:

Our Practice Dr. or Other Dr.

- |                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

YES NO

Are you taking Coumadin?

Are you taking Plavix?

## **ALLERGIES:**

Please list all allergies and reactions (if known)

<u>Drug</u>	<u>Reaction</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

**Are you allergic to Latex?** YES  NO

## **Family Medical History:**

Has anyone in your family had:	YES	YES
1. Allergies	<input type="checkbox"/>	<input type="checkbox"/>
2. Adopted - history not avail.	<input type="checkbox"/>	<input type="checkbox"/>
3. Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>
4. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
5. Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
6. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
7. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
9. Father -healthy/alive	<input type="checkbox"/>	<input type="checkbox"/>
10. Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
11. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
12. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
13. Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
14. Migraine	<input type="checkbox"/>	<input type="checkbox"/>
15. Mother healthy/alive	<input type="checkbox"/>	<input type="checkbox"/>
16. Stroke	<input type="checkbox"/>	<input type="checkbox"/>

## **Social History:**

	YES	NO
1. Alcohol Use?	<input type="checkbox"/>	<input type="checkbox"/>
2. Carpeted Home?	<input type="checkbox"/>	<input type="checkbox"/>
3. Central Air Conditioning?	<input type="checkbox"/>	<input type="checkbox"/>
4. Drug Use?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently smoke or use tobacco products? Have you Ever?	<input type="checkbox"/>	<input type="checkbox"/>
6. Exposed to second hand smoke?	<input type="checkbox"/>	<input type="checkbox"/>
7. Mold or Mildew in the home?	<input type="checkbox"/>	<input type="checkbox"/>
8. Pet's, Do you Have any? Circle > Cat(s), Dog(s), Horse(s), Rabbit(s)	<input type="checkbox"/>	<input type="checkbox"/>
9. Water Damage to home (past or present)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Woodstove?	<input type="checkbox"/>	<input type="checkbox"/>