Three Rivers Ear, Nose & Throat
Patient Profile

Name: _____ Today's Date: ___ _____

Date of Birth: _____ □ Male □ Female Race: _____

Drug Allergies

Allergy	Reactions

Current Medications List prescription, over-the-counter, and herbal meds

Name of Medication	Dose and number of times take per day

Past Medical History

Do you or have you had:	Yes	No	If "yes", please describe
Abdominal problems			(i.e., ulcers)
Allergies			If so, to what and what was the reaction?
Have you required allergy shots?			
Arthritis			
Bleeding disorders			
Cancer			
Contagious disease			
AIDS			
Hepatitis			A B C
Tuberculosis			
Venereal disease			
Diabetes			
Eye disease			(ie, glaucoma)
Head or facial injuries			
Hearing loss			
Heart problems			
Heart attack			
High blood pressure			
Kidney problems			
Liver problems			(ie, cirrhosis)
Lung problems			(ie, asthma, emphysema)
Neurologic problems			(ie, seizures)
Psychiatric problems			(ie, depression, anxiety disorder)
Stroke			
Thyroid problems			
Urologic problems			(ie, prostate, urinary)

Please list any other medical problems: _____

_____

Are you immunizations up to date? □ yes □ no If no, explain: _____

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Patient Profile (continued)

Name: _____ Today's Date: _____

Prior Surgeries

Type of surgery	Approximate date

Prior Hospitalizations

Reason	Approximate date

Family History

	yes	no	Relationship (mom, dad, grandparent, sibling, etc.)	maternal	paternal
Cancer (and type if known)					
Hearing loss					
Anesthesia problems					
Bleeding problems					
Lymphoma					
Leukemia					

Social History

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Minor Child
Family members in household: Children _____ Others:_____
Smoking: Packs per day _____ and for how long? _____
Chewing tobacco: How much _____ and for how long?_____
Smokers in the household? Yes____ No____
Alcohol use: Type_____ how much _____ and for how long? _____
Recreational or I.V. drug use: What type? _____ and for how long? _____
Pets in the house? Yes ____ No____ Type(s): _____

Are you currently experiencing any of the following?

□ Fever
□ Chills
□ Night sweats
□ Rashes
□ Blurred vision
□ Eye pain

□ Decreased hearing
□ Ear ringing
□ Ear pain
□ Ear drainage
□ Nose bleeding
□ Nose congestion

□ Sore throat
□ Difficulty swallowing
□ Neck pain
□ Neck swelling
□ Shortness of breath
□ Chest pain

□ Abdominal pain
□ Heartburn
□ Reflux of acid

□ Trouble urinating
□ Joint pain

□ Localized weakness
□ Seizures
□ Bleeding problems
□ Easy bruising
□ Unusual fatigue
□ Recent weight loss
How much?
Over how long?

□ Recent weight gain
How much?
over how long?

Additional Information: Please list any further information or details from the questionnaire here: _____

_____