

Panhandle Ear Nose & Throat Associates LLP

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PATIENT / FAMILY HISTORY

Although we primarily treat the area of ear, nose and throat, your ear, nose and throat are part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care you will receive. Please circle all the answers that apply to each question. Thank you for answering the following questions.

Patient Legal Name: _____ Pat_Last_Name _____ Appointment Date: _____ Appt_Next_Date _____

Patient is scheduled to see: Michael Guttenplan MD Stacie Morgan MD Martin Schneider MD Geoffrey Wright MD

Were you referred to our office by? Family Friend Patient Television Phone Book Web Site or a

Physician Yes No If Yes, by Dr.: _____

Emergency Room Yes No If Yes, what date were you seen: _____

Where were you seen: Baptist St. Anthony's Northwest Texas Hospital Other: _____

What problem(s) are you here for today? Ears Nose Throat Voice Hearing Dizziness

What symptoms are you here for today? _____

Are you allergic to any medications? Anesthetics Aspirin Codeine Penicillin Latex

Other – If Other, Explain: _____

Please list all medications and dosage you are taking?

MAKE SURE TO LIST ALL PRESCRIBED and ALL OVER THE COUNTER MEDICINES

LIST ALL PAST SURGERIES;

SOCIAL HISTORY:

Do You Smoke? Yes No How many packs per day? ¼ ½ 1 1 ½ 2 2 ½

Do you use smokeless tobacco or chewing tobacco? Yes No How many cans per day? ¼ ½ 1 1 ½ 2 2 ½

Do You Consume Alcoholic Beverages? Yes No What quantity and how frequent? _____

Do you use recreational drugs? Yes No If Yes, what type, what quantity and how frequent? _____

Have you had any recent diagnostic test such as: Barium Swallow Cat Scan MRI X-rays Biopsy Hearing Test

Other _____ How long ago? _____ Where was the test performed? _____

LIST GENERAL MEDICAL PROBLEMS: _____

Please review the following health history pertaining to the patient and the patient's family.

Please *circle the X* if the *patient* has a history and *circle the F* for a *family* member.

Patient	Family		Patient	Family		Patient	Family	
X	F	Anaphylaxis	X	F	Heart Trouble/Disease	X	F	Sickle Cell disease
X	F	Blood Transfusion	X	F	Hemophilia	X	F	Tuberculosis
X	F	Cancer	X	F	High Blood Pressure	X	F	Other – please explain below
X	F	Diabetes	X	F	Liver Disease			
X	F	Excessive Bleeding	X	F	Seizures			

Please review the following and place a check mark next to what applies: CHECK NONE IF APPLICABLE

General

- Fatigue
- Weight Loss
- Weight Gain
- Fever
- None

Ear, Nose & Throat

- Ear Pain
- Ringing in the Ears
- Hearing Loss
- Nasal Obstruction
- Nasal Drainage
- Sore Throat
- None

Heart & Lungs

- Shortness of Breath
- Swelling, Edema
- Chest Pain
- None

Stomach & Intestines

- Difficulty Swallowing
- Heartburn
- Vomiting
- Nausea
- Abdominal Pain
- Diarrhea
- Constipation
- Bleeding
- None

Urinary

- Bleeding
- Incontinence
- Difficulty Urinating
- None

Neurological

- Weakness
- Tingling
- Imbalance
- Poor Concentration
- Memory Loss
- Headaches
- Seizures
- Tremors
- None

Endocrine

- Cold Intolerance
- Heat Intolerance
- Change in Energy Level
- None

Psychiatric

- Depression
- Anxiety
- None

Musculoskeletal

- Joint Pain
- Weakness
- None

Did anyone come with you to your appointment today? Yes No If Yes, what is their name and how are they related to you?

Name: _____

Relationship: _____