DODID#:

OTOLARYNGOLOGY-HEAD AND NECK SURGERY (ENT)

DATE:_____ **APPT TIME:**_____ **CHECK-IN TIME:**_____

1. FULL NAME:_____,_____ **DOB:**_____

2. RANK:_____ **DODID#:**_____ **PHONE:**_____ - _____

3. REASON FOR APPOINTMENT / WHY ARE YOU HERE TO SEE ENT TODAY?

_____

_____

4. LIST ALL MEDICAL PROBLEMS: (ie, High Blood Pressure, Diabetes, Heart Disease):

_____

_____

_____

5. LIST ALL PRIOR SURGERIES AND YEAR:

_____

_____

_____

6. LIST ALL MEDICATIONS (Include over-the-counter and diet supplements)
Or, EDIT THE PROVIDED MEDICATION PRINTOUT:

_____

_____

_____

7. LIST ALL ALLERGIES:

_____

_____

8. DO YOU USE OR HAVE YOU EVER USED TOBACCO **YES** ☐ **NO** ☐
If currently using, amount per day? _____/ day **Type used:**_____
How many years? _____ **If no longer using, year quit:** _____

9. DO YOU DRINK ALCOHOL? YES ☐ **NO** ☐
If yes, amount per day: _____ **Type used (ie, Beer, Liquor, Wine):** _____
Have you ever felt you should cut down on your drinking? YES ☐ **NO** ☐

10. ARE YOU IN PAIN TODAY? YES ☐ **NO** ☐
Please rate your pain by circling your current pain level (0 = No pain, 10 = Worst pain ever)

0 ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐

WHERE IS YOUR PAIN: _____

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Please check the "Yes" or "No" box to indicate if you presently are experiencing any of the following symptoms:

		YES	NO			YES	NO
Allergy	Sneezing			**General**	Weight loss or gain		
	Post nasal drip				Fevers/Chills/Night sweats		
	Itchy/Watery eyes				Daytime sleepiness		
	Throat itching				Anesthesia Reaction		
ENT	Ear pain or itching			**Endocrine**	Heat intolerance		
	Hearing loss				Thyroid nodules / goiter		
	Dizziness / Vertigo				Cold intolerance		
	Nasal congestion				Diabetes		
	Sense of smell Problem			**Heme/lym**	Swollen glands		
	Hoarseness				Anemia		
	Throat clearing				Easy bruising		
	Facial cosmetic concerns				Bleeding disorder		
	Prior difficult intuabtion				Bleeding		
	Ear drainage				History of Cancer		
	Ear noise / ringing			**Cardio/Vasc.**	Chest Pain		
	Lightheadedness				Leg cramps		
	Sinus pressure/ pain				Prior Heart Attack		
	Snoring / Apnea				Abnormal heart beats		
	Dry mouth				Leg swelling		
	Throat pain				Pacemaker		
	Neck lump/ Swelling			**Musculosk.**	Jaw Pain		
Respiration	Cough				Joint aches/Swelling		
	Shortness of breath			**GU/GYN**	Excessive urination		
	Tuberculosis				Kidney stones		
	Wheezing				Are you pregnant		
	Emphysema/COPD			**Skin**	Rashes		
	Asthma				Poor Scarring/Keloid		
Eyes	Glaucoma			**Psych**	Depression		
	Double vision				PTSD		
	Blurred vision				Anxiety		
	Blindness				Psychiatric illness		
GI	Painful swallowing			**Neuro**	Headaches		
	Acid reflux				Balance problems		
	Heartburn				Weakness / Numbness		
	Stomach ulcers				Seizures/Epilepsy		
	Difficulty swallowing				Prior Stroke/TIA		
	Hiatal hernia				Paralysis		
	Liver disease			**Family History**	Cancer		
	Hepatitis				Hearing loss		
					Bleeding disorder		

DODID#: _____ DOB: _____