Albany ENT & Allergy Services -- Adult Patient Health Care Survey

Name	DOB	Date	Accompanied to Visit by

☐ Mom ☐ Dad
☐ Grandparent
☐ Caregiver

Please describe the reason for your visit today:

What treatments or testing have you tried for this problem? Please list over the counter as well as prescription medications. Please also include any allergy testing, CAT scans, MRI, Bloodwork, hearing tests or sleep study that you may have had.

Have you seen any other providers to evaluate this problem?

Please Mark All of Your Current Symptoms:

Constitutional
- ☐ Chills
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

Ears
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Ringing in the Ears
- ☐ Excessive Ear Wax
- ☐ Vertigo
- ☐ Ear Pressure
- ☐ Noise Exposure

Cardiovascular
- ☐ Chest Pain

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting

Nose and Sinus
- ☐ Nasal Congestion
- ☐ Sinus/Facial Pain
- ☐ Sinus Problems
- ☐ Nasal Bleeding
- ☐ Postnasal Drip
- ☐ Sneezing
- ☐ Diminished Smell
- ☐ Can't Breathe Through
- ☐ Nasal Discharge

Hematologic
- ☐ Abnormal Bleeding
- ☐ Lymph Node Swelling

Throat & Mouth
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Mouth Sores
- ☐ Drooling
- ☐ Taste Change
- ☐ Pain with Swallowing
- ☐ Sore Throat
- ☐ Lump in Throat
- ☐ Coughing Blood
- ☐ Neck Mass

Eyes
- ☐ Itchy Eyes
- ☐ Changes in Vision

Allergy/Immunologic
- ☐ Environmental Allergies
- ☐ Immunosuppression

Neurologic
- ☐ Difficulty Falling Asleep
- ☐ Excessive Daytime Sleepiness
- ☐ Headache
- ☐ Loss of Balance

Integumentary
- ☐ Altered Level of Consciousness
- ☐ Rash
- ☐ Frequent Itching

Respiratory
- ☐ Breathholding during sleep
- ☐ Snoring
- ☐ Shortness of Breath
- ☐ Cough

Musculoskeletal
- ☐ Neck Pain

Genitourinary
- ☐ Urinary Tract Infections

Psychiatric
- ☐ Depression
- ☐ Mood Swings

Please list any other symptoms you are having currently:

Family History

Please check all that apply.

	Mother	Father	Sister	Brother
Alive and Doing Well	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯
Hearing Loss	◯	◯	◯	◯
Environmental Allergies	◯	◯	◯	◯
Asthma	◯	◯	◯	◯
Thyroid Disease	◯	◯	◯	◯
Bleeding Disorder	◯	◯	◯	◯
Cancer (List Type)				
Cause of Death				

Other Family History

Past Medical & Surgical History

Patient Name | Date of Birth

If none in any category check None and Move Ahead to the next section.

☐ None

Allergy/Immunology

Allergies - Not Related to Medication ☐ Yes ☐ No — If Yes, List

Have you ever been on allergy shots? ☐ Yes ☐ No — If Yes: ◯ Shots Currently ◯ Shots In the Past

Reaction to X-Ray Dye? ☐ Yes ☐ No — If Yes, describe

Reaction to Anesthesia? ☐ Yes ☐ No — If Yes, Describe ◯ General ◯ Local

Contact Dermatitis ☐ Yes ☐ No

☐ None

Bone and Joint Health

Orthopaedic Surgery ☐ Yes ☐ No — Please list

☐ None

Cardiovascular

Deep Vein Thrombosis ☐ Yes ☐ No
Blood Clot/DVT ☐ Yes ☐ No
Cardiac Arrythmia ☐ Yes ☐ No
Cardiac Valve Replacement ☐ Yes ☐ No

Cardiac Bypass/CABG ☐ Yes ☐ No
Congestive Heart Failure ☐ Yes ☐ No
High Blood Pressure/Hypertension ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No
If Yes, do you require antibiotic prophylaxis for procedures? ☐ Yes ☐ No

☐ None

Ear, Nose & Throat

Chronic Ear Infections ☐ Yes ☐ No
Hearing Loss ☐ Yes ☐ No
Chronic Sinus Infections ☐ Yes ☐ No
Tonsillectomy ☐ Yes ☐ No
Ear Surgery ☐ Yes ☐ No
List

Ear Tubes ☐ Yes ☐ No
Adenoidectomy ☐ Yes ☐ No
Nasal Polyps ☐ Yes ☐ No
Nasal Sinus Surgery ☐ Yes ☐ No
List
TMJ/Temporomandibular Joint Disease ☐ Yes ☐ No

☐ None

Eyes

Glaucoma ☐ Yes ☐ No
Cataract Surgery ☐ Yes ☐ No
Lasik ☐ Yes ☐ No

☐ None

Immunizations

Up to date? ☐ Yes ☐ No — Fill in Dates

Influenza	Tetanus	Pneumococcal

☐ None

Gastrointestinal

GERD/Heartburn / Reflux ☐ Yes ☐ No
Eosinophilic Esophagitis ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No

☐ None

Hematology

Anemia ☐ Yes ☐ No
Bleeding Disorder / Hemaphilia ☐ Yes ☐ No

☐ None

Infectious

AIDS ☐ Yes ☐ No
HIV ☐ Yes ☐ No
Lyme Disease ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Methicillin-Resistant Staphylococcus Aureaus (MRSA) ☐ Yes ☐ No

☐ None

Kidney/Urinary

Kidney Disease ☐ Yes ☐ No
Kidney Failure ☐ Yes ☐ No
If Yes, Describe

☐ None

Neurology

Migraine Headaches ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No
Seizure Disorder/Epilepsy ☐ Yes ☐ No
Stroke/TIA ☐ Yes ☐ No

Patient Name

Date of Birth

If none in any category check None and Move Ahead to the next section.

☐ None

Metabolic/Endocrine

Diabetes ☐ Yes ☐ No

Thyroidectomy ☐ Yes ☐ No If Yes ☐ Partial ☐ Complete

Thyroid Nodule ☐ Yes ☐ No

Other Thyroid Disease: ☐ Yes ☐ No

If Yes, Describe Other Thyroid Disease

☐ None

Oncology

Cancer ☐ Yes ☐ No If Yes Type ◯ Breast ◯ Prostrate ◯ Ovarian ◯ Lung ◯ Leukemia ◯ Head and Neck

Describe

Have you had chemotherapy? ☐ Yes ☐ No

Have you had radiation therapy? ☐ Yes ☐ No

◯ Other Describe

☐ None

Psychiatric

ADD/ADHD ☐ Yes ☐ No

Alcoholism ☐ Yes ☐ No

Drug Abuse ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Bipolar Disease ☐ Yes ☐ No

Other Mental Illness ☐ Yes ☐ No

If Yes, Type

☐ None

Respiratory

Asthma ☐ Yes ☐ No

Sleep Apnea ☐ Yes ☐ No

Blood Clot/DVT/Deep Vein Thrombosis/ Pulmonary Embolism ☐ Yes ☐ No

COPD/Emphysema ☐ Yes ☐ No

Please list any past Medical or Surgical History Not Indicated Above

Medical History	Surgical History

Are you currently taking any medications? ☐ Yes ☐ No **Please list current medications below:**

(include over the counter and prescription)

Do you have any medication allergies? ☐ Yes ☐ No

If Yes, Please List all Known Allergies below:

Local Pharmacy Name

Phone #

Mail Order Pharmacy

Phone #

Lab for Blood Tests

Habits

Do you drink Alcohol? ☐ Yes ☐ No **If Yes, Frequency** ☐ Social ☐ Rare ☐ Daily ☐ Recovering Alcoholic

An accurate smoking history helps us to assess your risk for certain disorders. Please answer all applicable questions .

Do you smoke? ☐ Yes ☐ No If Yes, what do you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chew Other

How many years have you smoked?

How much do you smoke per day?

For cigarette smokers answer in average number of pack(s) per day

Have you ever smoked? ☐ Yes ☐ No If Yes, what did you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chew Other

How many years did you smoke?

How much did you smoke per day?

For cigarette smokers answer in average number of pack(s) per day

Is there secondhand smoke exposure at home? ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____