

Shohet Ear Associates Medical Group, Inc.

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CLINICAL HISTORY FORM-Part 1

First Name: _____ Middle: _____ Last: _____
 SSN: _____ Date of Birth: ____/____/____
 Address: _____ City _____ State _____ Zip _____
 Home Phone: () _____ - _____ Day Phone: () _____ - _____ Referred by: _____
 Primary Care Physician: _____
In case of emergency, please list a contact person: Name: _____ **Phone Number:** () _____ - _____
Address: _____
Email address: _____

CHIEF COMPLAINT

Reason(s) for Visit:

1. _____
 2. _____

Location(s): _____ **Historian:** _____

Onset: _____ days _____ weeks _____ months _____ years

Duration: 15 mins. 30 mins. 1hr. 2hrs. Variable _____

Frequency: Intermittent Occasional Constant Random

Status: improving unchanged worsening resolved

Severe of Symptoms: mild moderate severe incapacitating

Comments:

ALLERGIES (Select any allergies & document reactions)

No Allergies

<input type="checkbox"/> Accupril (quinapril)	<input type="checkbox"/> Codeine	<input type="checkbox"/> Heparin	<input type="checkbox"/> Morphine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Contrast Media (Ioversol)	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Motrin (ibuprofen)	<input type="checkbox"/> Tagamet (cimetidine)
<input type="checkbox"/> Advil (Ibuprofen)	<input type="checkbox"/> Coumadin	<input type="checkbox"/> Inderal (propranolol)	<input type="checkbox"/> Naprosyn (naproxen)	<input type="checkbox"/> Tegretol (carbamazepine)
<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Darvon	<input type="checkbox"/> Indocin (indomethacin)	<input type="checkbox"/> Niacin	<input type="checkbox"/> Tetanus toxoid
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Demerol	<input type="checkbox"/> Insulin (animal)	<input type="checkbox"/> Oxycodone	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Augmentin (amoxicillin)	<input type="checkbox"/> Depakote	<input type="checkbox"/> Iodine or shellfish	<input type="checkbox"/> Peanut	<input type="checkbox"/> Valium (diazepam)
<input type="checkbox"/> Bactrim (sulfamethoxazole)	<input type="checkbox"/> Diamox	<input type="checkbox"/> Keflex (cephalexin)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Vancomycin
<input type="checkbox"/> Biaxin	<input type="checkbox"/> Dicloxacillin	<input type="checkbox"/> Lasix (furosemide)	<input type="checkbox"/> Percocet (oxycodone)	<input type="checkbox"/> Zithromax
<input type="checkbox"/> Ceclor (cefaclor)	<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Latex	<input type="checkbox"/> Plavix	
<input type="checkbox"/> Celebrex	<input type="checkbox"/> Egg	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Phenytoin	Other: _____
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Lipitor	<input type="checkbox"/> Quinolones	Reactions: _____
<input type="checkbox"/> Cipro (ciprofloxacin)	<input type="checkbox"/> Flagyl	<input type="checkbox"/> Micronase (glyburide)	<input type="checkbox"/> Ranitidine	
<input type="checkbox"/> Clinoril (sulindac)	<input type="checkbox"/> Floxin	<input type="checkbox"/> Minocin (minocycline)	<input type="checkbox"/> Septra (sulfamethoxazole)	

MEDICATIONS (List any medications you are currently taking)

No Medications

Drug Name	Dosage	Frequency	Status: Chronic, Acute, Discontinued

Name _____

ENT PAST MEDICAL HISTORY (Please check all that apply)				
<input type="checkbox"/> Allergies	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Grave's disease	<input type="checkbox"/> irregular heart rate	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Anemia	<input type="checkbox"/> COPD	<input type="checkbox"/> Headaches	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Speech disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stomach ulcer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Multinodular goiter	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Otosclerosis	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Cancer	<input type="checkbox"/> GERD	<input type="checkbox"/> Intestinal disorder	<input type="checkbox"/> Sinus Dx	Other: _____

SURGICAL HISTORY					
Please check all that apply.	Date		Date		Date
<input type="checkbox"/> Angioplasty	_____	<input type="checkbox"/> Colectomy	_____	<input type="checkbox"/> Pacemaker	_____
<input type="checkbox"/> Angioplasty w/ stent	_____	<input type="checkbox"/> Colostomy	_____	<input type="checkbox"/> Septoplasty	_____
<input type="checkbox"/> Stapes Surgery Right Ear	_____	<input type="checkbox"/> Ear Surgery	_____	<input type="checkbox"/> Sinus Surgery	_____
<input type="checkbox"/> Stapes Surgery Left Ear	_____	<input type="checkbox"/> Gastric bypass	_____	<input type="checkbox"/> Thyroidectomy	_____
<input type="checkbox"/> Pressure Equalization tube	_____	<input type="checkbox"/> Hernia repair	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Carpal tunnel release	_____	<input type="checkbox"/> Hip replacement	_____	<input type="checkbox"/> Throat Surgery	_____
<input type="checkbox"/> Cataract extraction	_____	<input type="checkbox"/> Lasik	_____	Other: _____	_____

ENT REVIEW OF SYSTEMS (Check only the ones you now have or have had recently)		
<p style="text-align: center;"><u>Constitutional</u></p> <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> fatigue <input type="checkbox"/> weight gain <input type="checkbox"/> fever <input type="checkbox"/> weight loss <input type="checkbox"/> other: _____	<p style="text-align: center;"><u>Cardiovascular</u></p> <input type="checkbox"/> chest pain <input type="checkbox"/> heart murmur <input type="checkbox"/> palpitations <input type="checkbox"/> other: _____	<p style="text-align: center;"><u>Metabolic/Endocrine</u></p> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> heat intolerance <input type="checkbox"/> increased thirst <input type="checkbox"/> other: _____
<p style="text-align: center;"><u>HEENT</u></p> <input type="checkbox"/> blurred vision <input type="checkbox"/> hoarseness <input type="checkbox"/> choking on liquids <input type="checkbox"/> mouth ulcers <input type="checkbox"/> choking on solids <input type="checkbox"/> ear pain <input type="checkbox"/> double vision <input type="checkbox"/> sore throat <input type="checkbox"/> dizziness <input type="checkbox"/> ringing in ears <input type="checkbox"/> drooling <input type="checkbox"/> vertigo <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> visual changes <input type="checkbox"/> ear drainage <input type="checkbox"/> hearing loss <input type="checkbox"/> other: _____	<p style="text-align: center;"><u>Gastrointestinal</u></p> <input type="checkbox"/> abdominal pain <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> heartburn <input type="checkbox"/> vomiting <input type="checkbox"/> other: _____	<p style="text-align: center;"><u>Neurological</u></p> <input type="checkbox"/> difficulty falling asleep <input type="checkbox"/> syncope <input type="checkbox"/> difficulty staying asleep <input type="checkbox"/> tingling <input type="checkbox"/> excessive daytime sleepiness <input type="checkbox"/> tremor <input type="checkbox"/> non-restorative sleep <input type="checkbox"/> weakness <input type="checkbox"/> numbness in extremities <input type="checkbox"/> other: _____
<p style="text-align: center;"><u>Respiratory</u></p> <input type="checkbox"/> apnea during sleep <input type="checkbox"/> snoring <input type="checkbox"/> shortness of breath <input type="checkbox"/> wheezing <input type="checkbox"/> other: _____	<p style="text-align: center;"><u>Genitourinary</u></p> <input type="checkbox"/> change in urine <input type="checkbox"/> urine frequency <input type="checkbox"/> dysuria <input type="checkbox"/> other: _____	<p style="text-align: center;"><u>Psychiatric</u></p> <input type="checkbox"/> anxiety <input type="checkbox"/> hallucinations <input type="checkbox"/> depression <input type="checkbox"/> other: _____