WOOSTER E.N.T. ASSOCIATES

Arun K. Mathur, M.D., F.A.C.S. James R. Hessler, M.D., Ph. D. Kevin K. Mathur, M.D., F.A.A.O.A.

Date: _____

Patient Name:_____ Male / Female Age:_____ Date of Birth:_____

Nickname:_____ Height _____ Weight _____ Occupation:_____

Mailing address_____ City _____ Zip Code_____

Phone# _____ Cell#_____ Social Security #_____

Marital Status: □ Married □ Single □ Divorced □ Domestic partner □ Widowed

Primary Care Physician_____ Referred by _____ Parent name _____ (if minor)

CHIEF COMPLAINT OF ILLNESS:

1. What is the reason for today's visit?_____
2. How long have you had this problem?_____
3. How often does this problem occur?_____
4. What other symptoms are you having?_____

PAST MEDICAL HISTORY (please check any illnesses you have):

□ High blood pressure	□ Asthma/Emphysema	□ Rheumatic fever	Others:_____
□ Kidney disease	□ Stroke, mini-stroke	□ Sinusitis	_____
□ Diabetes	□ Heart disease / Angina	□ Peptic ulcers	_____
□ Neck / Back disease	□ Hepatitis / Liver disease	□ Thyroid disease	_____

□ Cancer (please list type and date diagnosed) _____

PAST SURGICAL HISTORY (please check any surgeries you have had):

□ Heart bypass/valve	□ Gall bladder	□ Prostate removal	Others: _____
□ Coronary angioplasty	□ Lung surgery	□ Colon removal	_____
□ Carotid artery	□ Joint replacement	□ Appendix removal	_____
□ Vascular bypass	□ Back surgery	□ Sinus surgery	_____
□ Mastectomy	□ Brain surgery	□ Tonsillectomy	_____
□ Heart transplant	□ Liver transplant	□ Kidney transplant	_____

MEDICATIONS (list all your current medications and the dose you take):

_____

_____

_____

_____

Do you take Aspirin? □ Yes □ No

Do you take Coumadin? □ Yes □ No

Do you take Plavix? □ Yes □ No

ALLERGIES (list medications / foods you are allergic to and what happens when you take them):

_____

_____

FAMILY HISTORY (check all illnesses that run in your family):

□ Hearing loss	□ Alcoholism	□ Heart attack	Others:_____
□ High blood pressure	□ Psychiatric illness	□ Cancer	_____
□ Sickle cell anemia	□ Bleeding problems	□ Diabetes	_____
□ Poor circulation	□ Anesthesia reaction	□ Stroke	_____

SOCIAL HISTORY:
Have you ever smoked? □ Yes □ No (□ cigarettes, □ cigar, □ pipe)
How much and for how long have you smoked? _____packs per day for ____years Quit? Y/N when?_____
How much alcohol do you drink each day? _____
List any street drugs you currently use: _____
Do you have any drug addictions? □ Yes □ No

REVIEW OF SYSTEMS (check all symptoms you have had either now or in the past):

CONSTITUTIONAL
□ Weight loss_____pounds in the past____ weeks □ Fever, chills

EYES:
□ Double vision
□ Loss of vision
□ Eye pain

ENT:
□ Hearing loss
□ Ringing in the ears
□ Dizziness
□ Ear pain
□ Ear drainage
□ Nose Drainage
□ Nasal congestion
□ Facial pain
□ Headaches
□ Sore mouth/throat
□ Swallowing pain
□ Voice change
□ Snoring
□ Hoarseness
□ Poor sleep

CARDIOVASCULAR / PULMONARY:
□ Chest pain □ Heart attack □ Irregular heartbeat
□ Poor circulation □ Leg pain during walking □ Coughing up blood
□ Shortness of breath □ Asthma

GASTROINTESTINAL:
□ Stomach ulcers □ Nausea / vomiting □ Diarrhea
□ Blood in stool □ Trouble swallowing □ Abdominal pain

GENITOURINARY:
□ Blood in urine □ Pain during urination □ Difficulty making urine

MUSCULOSKELETAL:
□ Neck / Spine surgery □ Neck or back disorder □ Arthritis

NEUROLOGICAL:
□ Stroke □ Ministroke □ Temporary loss of vision or speech control
□ Loss of sensation □ Paralysis of an arm or leg □ Facial paralysis

SKIN:
□ Skin cancers □ Allergy to medical tape, iodine or latex

PSYCHIATRIC:
□ Clinical depression □ Schizophrenia □ Anxiety
□ Hallucinations □ Other psychiatric disorder (list) _____

INFECTIOUS DISEASE:
□ Hepatitis □ HIV / AIDS □ Mononucleosis
□ TB

I have personally reviewed this history and review of systems:

_____
Physician Signature Date