MEDICAL HISTORY - RONALD W. LI, M.D. – EAR, NOSE AND THROAT (page 1 of 3) - version 3A - 2/14/2013

Patient Name:		Age:	Sex:	*Recent Blood Pressure:*
Date:	Chart #:	Height:		Weight:
Referring Doctor:	Address:		Zip code:	Phone #:
Pharmacy Name (s): 1)	Address:		Zip code:	Phone #:
2)				

Describe the problem(s) which brought you here today:

SOCIAL HISTORY:

☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic partner ☐ Single

☐ Employed ☐ Unemployed ☐ Student ☐ Retired

SMOKING HISTORY:

Have you smoked at least 100 cigarettes in your entire life (yes/no)? _____
Do you currently smoke (yes/no)? _____
If yes, how much (cigarettes per day)? _____ How many years have you been smoking? _____

Do you use smokeless tobacco (yes/no)? ____
Are you at risk for second hand smoke (yes/no)? ____

ALCOHOL HISTORY:

Yes or No? ____
If yes, what kind of alcohol and how much do you drink per week? _____

ANTIBIOTIC PROPHYLAXIS:

Do you need to premedicate with an antibiotic before a surgical or dental procedure (Yes/ No)? _____
If yes, which antibiotic do you premedicate with and what is the dosage? _____

ANTICOAGULANT HISTORY:

Are you taking any blood thinners or anticoagulants like, Aspirin, Coumadin, Brilinta, or Plavix (clopidogrel) (Yes/No)? ___
If yes, which ones? _____

BLEEDING HISTORY:

Do you have a history of excessive bleeding or difficulty stopping bleeding (Yes/No)? _____
If yes, please explain: _____

LIVER OR KIDNEY PROBLEM:

Do you have a Liver or Kidney condition that requires an adjustment in the dosage of any medication(s) (Yes/No)? _____
If yes, please explain: _____

PREGNANCY HISTORY:

Are you currently pregnant (Yes/No)? _____ If yes, how many weeks? _____
When was your last menstrual period? _____

PAST MEDICAL HISTORY : (If Yes, check box to the LEFT. Add **ALL other unlisted** medical conditions.)

	Recurrent tonsillitis		Hypertension		Hepatitis (A,B or C)
	GERD or Reflux		Heart attack (MI)		Cancer (type):
	Sleep Apnea		Stroke or TIA		Other Conditions:
	Seasonal or perennial allergies		Asthma or COPD		
	Chronic or recurrent sinusitis		Diabetes		
	Recurrent ear infections		Migraine		
	Hearing loss or hearing aids		Tuberculosis		
	Hypothyroid or Hyperthyroid		HIV (AIDS)		

PAST SURGICAL HISTORY : (If Yes, check box to the LEFT and add date. Add **ALL other unlisted** surgeries.)

Type of surgery		Date (Year and month if known)	Type of surgery		Date (Year and month if known)
	Ear surgery			Thyroid surgery	
	Septoplasty			Pacemaker/defibrillator	
	Sinus surgery			Other:	
	Rhinoplasty				
	Tonsillectomy				
	Adenoidectomy				
	Uvulopalatopharyngoplasty				
	Peritonsillar abscess				
	Vocal cord surgery				

CURRENT MEDICATIONS:

Name	Dose	Frequency		Name	Dose	Frequency

DRUG ALLERGIES: (List names of drugs)

FAMILY HISTORY: (Circle family member)	Father	Mother	Brother/ Sister	Brother/ Sister	Brother/ Sister	Son/ Daughter	Son/ Daughter	Son/ Daughter
Health Status: answer with following choices - A=alive, D=deceased, U=unknown, **AND list age(s).**								
For each family member, check applicable boxes below if answer is YES, otherwise leave blank.								
Congenital or genetic hearing loss								
Age related hearing loss								
Bleeding disorder								
Hypertension								
Diabetes								
Asthma								
Cancer (type):								
Cancer (type):								
Other disease:								
Other disease:								

Name: _____ Chart # _____Date: _____

REVIEW OF SYSTEMS - RONALD W. LI, M.D. - EAR, NOSE & THROAT

I **currently** have the following symptoms (Circle Yes or No):

CONSTITUTIONAL:
Good General Health ..... Yes No
Fever ..... Yes No
Weight loss ..... Yes No
Fatigue ..... Yes No

EYES:
Eye pain ..... Yes No
Excessive tearing ..... Yes No
Double vision (Diplopia) ..... Yes No
Loss of vision ..... Yes No
Corrective lens (Eye glasses or Contact lens) ..... Yes No

ENT:
Hearing loss ..... Yes No
Hearing aids ..... Yes No
Ringing (Tinnitus) ..... Yes No
Ear pain (Otalgia) ..... Yes No
Ear pressure or fullness ..... Yes No
Ear drainage (Otorrhea) ..... Yes No
Dizziness or Imbalance ..... Yes No
Vertigo (Spinning sensation) ..... Yes No
Nose bleeds (Epistaxis) ..... Yes No
Sinus or nasal pain ..... Yes No
Nasal obstruction ..... Yes No
Post nasal drip ..... Yes No
Loss of smell (Anosmia) ..... Yes No
Loss of taste (salt, sweet, sour, bitter, or finer tastes) ..... Yes No
Distorted sense of taste (Dysgeusia) ..... Yes No
Mouth pain (sores, ulcers, or bleeding) ..... Yes No
Sore throat ..... Yes No
Sensation of a lump in the throat ..... Yes No
Difficulty swallowing (Dysphagia) ..... Yes No
Hoarseness or change in voice ..... Yes No
Neck mass or swelling ..... Yes No

CARDIOVASCULAR:
Chest pain ..... Yes No
Palpitations ..... Yes No
Heart murmur ..... Yes No
Swelling of legs ..... Yes No

RESPIRATORY:
Cough ..... Yes No
Wheezing ..... Yes No
Shortness of breath (Dyspnea) ..... Yes No
Snoring ..... Yes No
Sleep apnea ..... Yes No

GASTROINTESTINAL:
Nausea ..... Yes No
Vomiting ..... Yes No
Diarrhea ..... Yes No
Constipation ..... Yes No
Reflux (GERD) or Heartburn ..... Yes No

GENITOURINARY:
Frequent urination ..... Yes No
Painful or burning urination (Dysuria) ..... Yes No
Urinary incontinence ..... Yes No

MUSCULOSKELETAL:
Joint pain ..... Yes No
Muscle pain ..... Yes No

SKIN:
Rash ..... Yes No
Ulcer ..... Yes No
Hives ..... Yes No
Itchiness ..... Yes No

NEUROLOGICAL:
Headache ..... Yes No
Fainting episode (Syncope) ..... Yes No
Tremor ..... Yes No
Paralysis ..... Yes No
Muscle weakness (Paresis) ..... Yes No
Numbness ..... Yes No
Seizure history ..... Yes No

PSYCHIATRIC:
Anxiety ..... Yes No
Depression ..... Yes No
Memory loss or confusion ..... Yes No

ENDOCRINE:
Thyroid disease ..... Yes No
Diabetes ..... Yes No

HEMATOLOGIC/LYMPHATIC:
Bleeding/clotting disorder ..... Yes No
Lymph node enlargement ..... Yes No

ALLERGIC/IMMUNOLOGY:
Allergy (tree, grass, weed, pet, mold) ..... Yes No
Food allergy ..... Yes No
Anaphylaxis (bee sting, X 'ray dyes) ..... Yes No
Immune deficiency ..... Yes No

I have answered this form to the best of my knowledge:

Patient signature: _____

Date: _____

Print Patient Name: _____

Chart Number: _____

Reviewed by: _____