Princess Anne ENT & Allergy, PC.
828 Healthy Way, Suite 280, Virginia Beach, VA 23462

Patient Name: _____ **Family Doctor/PCP:** _____

Date: _____ **Pharmacy (Name/location/phone #):** _____
_____

Reason for today's visit? (What is your primary complaint?)

_____
_____
_____

Do you have **other ENT problems** that you would like to address? Please ***check*** all that apply.
(In order to stay on time, these may require a future visit – thank you.) ☐ **None**

	Allergy symptoms		Hearing loss
	Sinus problems		Ear drainage
	Nasal breathing problems		Facial or neck lesions/masses
	Deviated septum		Thyroid enlargement
	Frequent tonsillitis		Other:

Patient's Medical History: (Please ***check*** all problems for which ***you*** are currently or have previously been treated by a physician.) ☐ **None**

	Anemia (requiring transfusion)		Heart attack
	Asthma		High Blood Pressure
	Bleeding Disorder		Kidney problems (dialysis)
	Cancer		Liver problems (i.e. Hepatitis)
	Diabetes		Seizures
	Emphysema (COPD)		Stroke
	Glaucoma		Other:

Patient's Surgical History: (Please list all surgeries that ***you*** have ever had.) ☐ **None**

1.	**4.**
2.	**5.**
3.	**6.**

Medications: (Please list ***all*** current medications with dosage and frequency.) ☐ **None**

Medicine Name	Dosage	Frequency Taken
Example: Tylenol	325 mg	2 tablets every 4 hrs as needed

If you should need to reschedule or cancel your appointment, please contact our office at least 24 hours prior to your originally scheduled appointment time.

Drug Allergies: (Include type of allergic reactions) ☐ **None Known**

Medicine Name	Type of Reaction
Example: Tylenol	Swelling of lips, hives

Social History: (Please ***circle***)

Do you smoke cigarettes/cigars?	No	Yes	If yes, how much?	Packs per day
Do you use smokeless tobacco?	No	Yes		
Do you drink alcohol?	No	Yes	Socially	Daily
Do you use illegal drugs?	No	Yes		

Family History: (Please ***circle only if more than one*** family member has any of these conditions)

Allergy (i.e. hayfever)	Heart attack	Thyroid disorders
Asthma	High blood pressure	Thyroid cancer
Bleeding disorders	Nose bleeds	Other types of cancer
Diabetes	Seizures	Other:
Hearing loss	Stroke	

Review of Systems: (***circle*** all ***current*** symptoms)

Constitutional	fever, chills, decreased appetite, weight loss/gain
Eyes	eye pain, double vision, itchy eyes
ENT – Mouth	**Ears:** hearing loss, ringing, ear pain, ear discharge **Nose & Sinus:** decreased sense of smell, bleeding, obstruction, discharge **Throat & Mouth:** ulcers/lesions, trouble swallowing, hoarseness
Cardiovascular	chest pain, shortness of breath, rapid/abnormal heartbeat
Respiratory	dry cough, wheezing, coughing up blood
Gastrointestinal	nausea/vomiting, heartburn, abdominal pain, black stool
Integumentary (skin)	rash, change in skin lesion/moles, diffuse itching
Neurology	headache, memory loss, blackouts, tremor
Psychiatric	anxiety, depression, hallucination
Endocrine	heat/cold intolerance, unusual hair loss, excessive thirst
Allergic/Immunologic	dry skin/rashes, hives

Other important health information: (Please ***circle***)

Are you pregnant?	No	Yes	
Have you had prior problems with anesthesia?	No	Yes	If yes, type of reaction?
Do you have chest pain or abnormal heartbeat?	No	Yes	
Do you have prolonged bleeding when you are cut?	No	Yes	
Are you taking aspirin daily?	No	Yes	
Do you have HIV?	No	Yes	

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