MILE HIGH
OTOLARYNGOLOGY

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PATIENT INFORMATION SHEET

Today's Date _____ Patient Name _____ Date of Birth _____

Primary Care Physician (PCP) _____

Reason for today's visit _____

PHARMACY NAME/CROSS STREETS

_____

Medications

Do you take any ***prescription*** medications or supplements on a regular basis? ☐ Yes ☐ No

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Social History

Do you use tobacco? ☐ Never ☐ Former smoker (date quit) _____

☐ less than 1 pack per day ☐ 1 pack per day ☐ 1-2 packs per day ☐ 3 packs per day ☐ Chewing tobacco

Do you use alcohol? ☐ Never ☐ Rarely ☐ Socially ☐ Moderately ☐ Heavily

Family History

☐ Hearing loss ☐ Anesthesia problems ☐ Cancer (if yes, what type?) _____ ☐ Heart disease ☐ Diabetes

Serious Illnesses/Non-Surgical Hospitalizations

List all current or chronic illnesses (diabetes, heart disease, etc.).

1. _____ 2. _____

3. _____ 4. _____

Allergies

Do you have an allergy to latex? ☐ Yes ☐ No Do you have an allergy to any medications? ☐ Yes ☐ No If so, please list.

1. _____ 2. _____

3. _____ 4. _____

Surgical History

List any surgeries you have had.

1. _____ 2. _____

3. _____ 4. _____

Have you ever had problems with general anesthesia? ☐ Yes ☐ No Have you ever had a blood transfusion? ☐ Yes ☐ No

Today's Date _____ Patient Name _____ Date of Birth _____

Do you or have you ever had any of the following ENT problems or symptoms?

- ☐ Ear infections
- ☐ Ear pain
- ☐ Hearing problems
- ☐ Ringing in the ears
- ☐ Dizziness
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Nasal drainage
- ☐ Nasal trauma
- ☐ Sinus infections
- ☐ Nasal obstructions
- ☐ Nosebleeds
- ☐ Facial pain
- ☐ Change in taste/smell
- ☐ Headache
- ☐ Tonsillitis
- ☐ Sore throat
- ☐ Mouth lesions
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Pain with swallowing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Neck mass
- ☐ Head/neck cancer

Do you or have you ever had any of the following conditions or symptoms?

CONSTITUTIONAL
- ☐ Fever
- ☐ Chills
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fatigue
- ☐ Other _____

CARDIAC
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Angina
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Heart valve disease
- ☐ Rheumatic fever
- ☐ Other _____

PULMONARY (LUNGS)
- ☐ Wheezing
- ☐ Exercise intolerance
- ☐ Other _____

DIGESTIVE
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hiatal hernia
- ☐ Heartburn
- ☐ Reflux disease
- ☐ Ulcers
- ☐ Irritable bowel
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Liver disease
- ☐ Other _____

ENDOCRINE
- ☐ Diabetes
- ☐ Low thyroid
- ☐ High thyroid
- ☐ Stroke/CVA
- ☐ Other _____

SKIN
- ☐ Rash
- ☐ Eczema
- ☐ Other _____

BLOOD/IMMUNE SYSTEM
- ☐ Swollen glands
- ☐ Blood clots/DVT/PE
- ☐ Easy bleeding
- ☐ Anemia
- ☐ Cancer
- ☐ Lupus
- ☐ Other _____

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Neck/back problems
- ☐ Osteoporosis
- ☐ Other _____

PSYCHOLOGIC/EMOTION
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Recent increase in stress
- ☐ Other _____

INFECTIOUS DISEASE
- ☐ HIV
- ☐ Hepatitis A/B/C
- ☐ Tuberculosis
- ☐ Measles
- ☐ Mumps
- ☐ Other _____

COGNITIVE CHANGES
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Other _____

OTHER NEUROLOGIC
- ☐ Loss of strength
- ☐ Numbness/tingling
- ☐ Seizures/epilepsy
- ☐ Multiple sclerosis