Affinity Ear Nose and Throat
New Patient

Patient Name: _____ DOB: _____ Date: _____

What brings you into the office today? _____

Review of Systems

Place a check in each box that applies to the patient, if there are "No" problems check "No Complaints"

General
☐ Fever ☐ Chills ☐ Weight Loss
☐ Malaise ☐ Night Sweats
☐ No Complaints

Eyes
☐ Vision Loss ☐ Double Vision
☐ Blurred Vision ☐ Dryness ☐ Itching
☐ Pain ☐ No Complaints

Ears
☐ Pain ☐ Pressure ☐ Popping ☐ Ringing
☐ Tubes ☐ Frequent Infections
☐ Discharge ☐ Bleeding ☐ Vertigo/Dizzy
☐ Itching ☐ Hearing Loss__R__L__Both
☐ No Complaints

Nose
☐ Trauma ☐ Obstruction ☐ Discharge
☐ Post Nasal Drip ☐ Loss of Smell
☐ Teeth Pain ☐ Bleeding
☐ Facial Pain/Headaches ☐ Sneezing
☐ Allergy ☐ No Complaints

Mouth/Throat
☐ Soreness ☐ Frequent Infections
☐ Swelling ☐ Painful Swallowing
☐ Difficulty Swallowing ☐ Ulcers
☐ No Teeth ☐ No Complaints

Neck
☐ Thyroid Problems ☐ Tenderness
☐ Swelling ☐ Mass ☐ No Complaints

Cardiovascular (Heart)
☐ Chest Pain ☐ Palpitations ☐ Murmur
☐ High Blood Pressure ☐Tightness in Chest
☐ No Complaints

Respiratory (Lungs)
☐ Shortness of Breath ☐ Cough
☐ Wheezing ☐ Asthma ☐ Cough Blood
☐ Hoarseness ☐ No Complaints

Gastrointestinal (Stomach/Bowels)
☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Bloody Stool ☐ Irritable Stomach
☐ Liver Problems ☐ No Complaints

Urinary
☐ Painful Urination ☐ Bleeding
☐ Difficult Urination ☐ No Complaints

Musculoskeletal
☐ Weakness ☐ Pain ☐ No Complaints

Skin
☐ Rash ☐ Itching ☐ Growth
☐ No Complaints

Neurological
☐ Numbness ☐ Paralysis/Paresis
☐ Headache ☐ Tremor ☐ No Complaints

Psychiatric (Mental Health)
☐ Paranoia ☐ Delusions ☐ Depression
☐ Agitation ☐ No Complaints

Endocrine
☐ Hair Loss ☐ Nervousness
☐ No Complaints

Hematologic/Lymphatic
☐ Easy Bruising/Bleeding
☐ Enlarged Glands ☐ HIV
☐ No Complaints

Allergic/Immunologic
☐ Hay Fever ☐ Food Intolerance ☐ Insects
☐ Chemicals ☐ No Complaints

History

Place a check in each box and fill in the blanks appropriately as they apply to the patient

Past Medical History

Diabetes Mellitus	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No
Head/Neck Cancer	☐ Yes ☐ No

Social History
Occupation _____
Tobacco _____ packs/day for _____ years
Alcohol _____ glasses/cans per day
Caffeine _____ ounces/day
Illicit Drug Use _____ Type _____
Sun Exposure _____ hours/day
Noise Exposure _____ hours/day
Noise Type _____

Family History

☐ Asthma	Relation_____
☐ Breast Cancer	Relation_____
☐ Colon Cancer	Relation_____
☐ COPD	Relation_____
☐ Diabetes	Relation_____
☐ Blood Pressure	Relation_____
☐ Lung Disease	Relation_____
☐ Migraines	Relation_____
☐ Osteoporosis	Relation_____
☐ Lung Disease	Relation_____

Past Surgical History
_____
_____
_____

Current Medications
_____
_____
_____

Allergies
_____
_____
_____