DATE:

CHART #

NAME: DATE OF BIRTH:

E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **List your allergies to medicines**   * No drug allergies * Penicillin * Sulfa * Codeine * Anesthetics * Other – List Below | **Race / Ethnicity**   * White * African-American * Hispanic * American Indian * European * Asian * Other   **Preferred Language**   * English * Spanish * Other | **Do you take any medications?**  YES NO  **Please list them below.** | **Do you have the following?**    Diabetes YES NO  Hypertension YES NO  Heart Disease YES NO  **List any other medical conditions.** |
| **Does any blood relative have:**   * Bleeding tendency * Allergy problems * Diabetes * Hepatitis B * Hearing loss * Heart disease | **Social History**  Alcohol \_\_\_\_\_\_\_\_\_\_ oz / day    Smoke? No Yes Former  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ packs/day  Smokeless tobacco?  Do you have second hand smoke  Exposure? If yes, please circle    Home Work Social | **May we contact your pharmacy to get your medication history?**  YES NO  **Preferred Pharmacy:** | **List any surgeries you have had.**   * NONE |

I authorize and consent to my blood being tested for communicable diseases **if any person is exposed** to my blood or other bodily fluids at the ENT and Allergy Center. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS (please circle if present)

**Constitutional**: Night Sweats Fatigue Weight Loss

**Eyes**: Blurred Vision Double Vision Eye Pain

**Heart**: Chest Pain Heart Palpitations Swelling in Legs

**Lungs**: Cough Spitting up Blood Shortness of Breath

**GI**: Nausea Acid Reflux Difficulty Swallowing

**Bone/Joint**: Joint Pain Joint Swelling Muscle Cramps or Weakness

**Skin**: Rash Skin Cancer

**Psychiatric**: Anxiety Depression

**Hematology**: Easy Bruising Blood Clots Lymph Node Enlargement

**Allergy**: Sneezing Itching/Watery Eyes