DATE:

CHART #

NAME: DATE OF BIRTH:

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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 NOHypertension YES NOHeart 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