# ENT PATIENT INFORMATION SHEET

**NAME:** _____ **DOB:** _____ **DATE:** _____

**REASON FOR VISIT**: _____

**ALLERGIES/INTOLERANCES**: Include non-medication allergies and or intolerances

_____ _____ _____

_____ _____ _____

**MEDICATIONS:** List all medications you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____

_____ _____ _____

_____ _____ _____

**PERSONAL MEDICAL HISTORY:** (Please circle all that apply)

| | | | | |
|---|---|---|---|---|
| ADHD | Bleeding Problems | GERD (Acid Reflux) | Hepatitis | Psoriasis |
| Alcoholism | Cancer:_____ | Glaucoma | IBS (Irritable Bowl) | Pulmonary Embolism |
| Allergies, Seasonal | Headaches | Heart Disease | Lupus | Rheumatoid Arthritis |
| Anemia | Crohn's Disease | Heart Attack | Liver Disease | Seizure Disorder |
| Anxiety | COPD/Emphysema | Hiatal Hernia | Macular Degeneration | Sleep Apnea |
| Arrhythmia | Dementia | High Blood Pressure | Neuropathy | Stroke |
| Arthritis | Depression | Kidney Stones | Osteopenia/Osteoporosis | Thyroid Disorder |
| Asthma | Diabetes: 1 or 2 | Kidney Disease | Parkinson's Disease | Ulcerative Colitis |
| Bipolar | Diverticulitis | High Cholesterol | Narrowed Blood Vessels | |
| Bladder Problems | DVT (Blood Clot) | HIV | Peptic Ulcer | |

**Other medical problems not listed above:**

_____

**Surgical History:** Please list all prior surgeries and approximate dates performed.

_____

**SOCIAL / CULTURAL HISTORY:**

Smoking/Tobacco/Vape Use: ☐ Never ☐ Past ☐ Current Type: _____ Amount/Day: _____ Number of Years: _____

Alcohol: ☐ Never ☐ Past ☐ Current Drinks/Week: _____

Recreational Drug Use: ☐ Never ☐ Past ☐ Current Type: _____

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

*Updated: 06/11/2024*

## FAMILY HISTORY:

**FATHER:** Living: Age _____ Deceased: Age _____

| | | | | |
|---|---|---|---|---|
| Alcoholism | Bipolar Disorder | Depression | High Cholesterol | Osteoporosis |
| Anemia | Cancer: _____ | Diabetes 1 or 2 | High Blood Pressure | Stroke |
| Asthma | COPD/Emphysema | DVT (Blood Clot) | Kidney Disease | Thyroid Disorder |
| Arthritis | Dementia | Heart Disease | Migraines | |

Other: _____

**MOTHER:** Living: Age _____ Deceased: Age _____

| | | | | |
|---|---|---|---|---|
| Alcoholism | Bipolar Disorder | Depression | High Cholesterol | Osteoporosis |
| Anemia | Cancer: _____ | Diabetes 1 or 2 | High Blood Pressure | Stroke |
| Asthma | COPD/Emphysema | DVT (Blood Clot) | Kidney Disease | Thyroid Disorder |
| Arthritis | Dementia | Heart Disease | Migraines | |

Other: _____

**SIBLINGS:** _____

**List other medical providers you see on a regular basis** (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____