E.N.T. GROUP OF CLEVELAND, INC.

Name:_____Birthdate:_____/_____/_____Date:_____/_____/_____

Reason for Visit:_____

Referring Physician:_____

*Primary Care Physician:_____

May we provide him/her with update information? Yes_____ No_____

PATIENT HISTORY

DRUG ALLERGIES? (*If none, please write "none"*)_____

LATEX ALLERGY? YES ☐ NO ☐

CURRENT MEDICATIONS? *(Include vitamin or dietary supplements)*_____

_____

SURGERIES?_____

***Have you ever had or do you have …* Hepatitis A ☐ B ☐ or C ☐ ? H.I.V.? ☐**

☐Alcoholism	☐Cancer	☐Kidney Disease	☐Other_____
☐Anemia	☐Diabetes	☐Liver Problem	
☐Angina/Heart Attack	☐Emphysema	☐Lung Problem	☐Other_____
☐Arthritis	☐Epilepsy or Seizures	☐Mental Illness	
☐Asthma/Hay Fever	☐Glaucoma	☐Stroke	☐Other_____
☐Birth Defects	☐Headaches	☐Thyroid Problem	
☐Bladder Disease	☐Heart Failure	☐Tuberculosis	
☐Bleeding Disorder	☐High Blood Pressure	☐Venereal Disease	

FAMILY HISTORY

Has anyone in your family had … (Please indicate family member next to condition)

☐Alcoholism	☐Cancer	☐Kidney Disease	☐ Other_____
☐Anemia	☐Diabetes	☐Liver Problem	
☐Angina/Heart Attack	☐Emphysema	☐Lung Problem	☐ Other_____
☐Arthritis	☐Epilepsy or Seizures	☐Mental Illness	
☐Asthma/Hay Fever	☐Glaucoma	☐Stroke	☐ Other_____
☐Birth Defects	☐Headaches	☐Thyroid Problem	
☐Bladder Disease	☐Heart Failure	☐Tuberculosis	
☐Bleeding Disorder	☐High Blood Pressure	☐Venereal Disease	

SOCIAL HISTORY

Do you … ☐ Exercise Regularly? Type:_____ How often?_____

☐ Use Caffeine? How often?_____

☐ Use Alcohol? (Beer/Wine/Liquor) How often?_____

☐ Use Tobacco? (Cigarettes/Cigars/Pipe/Snuff/Chew) How often? _____

*If you used tobacco in the past: How often?_____ When did you quit?_____

☐ Use Drugs? (Marijuana/Heroin/Cocaine/LSD/Crack) How often? _____

PHARMACY

Local Pharmacy:_____

Address:_____City_____State_____Zip_____

Phone:_____