ENT & Allergy Specialists

Patient History Form

CENTER FOR Surgical Care

Name_____ DOB _____ Todays Date_____

Family MD_____Referring MD_____Height_____Ft ._____Inches Weight_____ Lbs

Why are you here today?

Are you aware of any new medical problems, medications, or allergies since last see at ENT & Allergy Specialists? ☐ Yes ☐ No

If applicable, please review the provided medical history form. Cross out any items that no longer apply, add items as needed.

Please Circle any symptoms below that you have experienced recently. **Check box if you have no symptoms** ☐

Decreased Hearing	Snoring	Jaw Pain	Other:
Difficulty Understanding	Sore Throat	Joint Pain	
Ear Drainage	Fevers/Chills/Sweats	Rash	
Ear Pain	Headache	Eczema	
Noises in the Ear	Facial Pain	Anxiety	
Dizziness or Vertigo	Fatigue or daytime sleepiness	Depression	
Nasal Congestion	Recent & unexpected weight loss	Heat intolerance	
Nasal Drainage	Changes in vision/poor vision	Cold intolerance	
Nosebleeds	Watery or itchy eyes	Abnormal or easy bruising	
Sinus Pain	Chest Pain	Abnormal bleeding	
Sneezing	Shortness of breath with exertion	Swollen Glands	
Sense of Smell problem	Shortness of breath at rest	Hay Fever	
Difficulty Swallowing	Cough	HIV or Hepatitis C exposure	
Throat Clearing	Heartburn		
Hoarseness	Kidney Stones		

To the best of my knowledge, my information on this form is accurate and complete.

Signature of patient, parent or guardian: _____ Date:_____

Relationship to patient:_____

FOR OFFICE USE ONLY

Initial when reviewed

Date: Initials:

MD/CRNA COMMENTS AND NOTES

Surgery Scheduled: Date:

Physician:

Anesthesia Plan: P.S. I II III Signature: