Oregon Ear, Nose and Throat Center

Patient Name: _____ **Date of Birth:**_____ **Age:** _____ **Gender: M F**

Reason for today's visit: _____

Current List of Medications - Please list name, dosage and frequency. Include supplements (vitamins, herbs, etc.)

_____

_____

_____

_____

Allergies to Medications:_____

Does patient have a history of a bleeding disorder? Y N **Allergic to Eggs? Y N** **Allergic to Soy: Y N**

Does patient have a personal history of anesthesia reaction? Y N Details:_____

Does family member have a history of anesthesia reaction? Y N Details:_____

Past Medical History: (PLEASE CHECK BOX NEXT TO THE CONDITION PATIENT HAS NOW OR HAD IN THE PAST)

- □ Latex allergy - YES
- □ Latex allergy – NO

Eyes
- □ Glaucoma
- □ Cataract

ENT
- □ Hearing loss
- □ Cholesteatoma
- □ Recurrent tonsillitis
- □ Chronic sinusitis
- □ Nasal polyps
- □ Broken nose
- □ Broken facial bones
- □ Obstruct sleep apnea
- □ Meniere's Disease
- □ Otosclerosis

Cardiovascular
- □ Hypertension/High BP
- □ Coronary artery disease
- □ Atrial fibrillation
- □ Other arrhythmia
- □ Congestive heart failure
- □ Valvular heart disease
- □ Varicose veins/phlebitis

Respiratory
- □ Asthma
- □ COPD
- □ Lung cancer

Gastrointestinal
- □ GERD/Acid Reflux
- □ Peptic ulcer
- □ GI bleed
- □ Liver disease
- □ Cirrhosis
- □ Colon cancer
- □ Crohn's disease
- □ Diverticulitis
- □ Renal failure
- □ Kidney disease
- □ Prostate enlarged
- □ Prostate cancer
- □ UTI-Recurrent
- □ Infertility

Musculoskeletal
- □ Osteoarthritis
- □ Osteoporosis
- □ Rheumatoid arthritis
- □ Broken bones
- □ Muscular dystrophy

Neurologic
- □ CVA/Stroke
- □ Brain tumor
- □ Seizure disorder
- □ Multiple sclerosis
- □ Anxiety
- □ Depression
- □ Bipolar
- □ Schizophrenia

Endocrine
- □ Diabetes Type I
- □ Diabetes Type II/oral
- □ Hypothyroidism
- □ Hyperthyroidism
- □ Thyroid disorder

Skin
- □ Skin disease

Hem/Lymphatic
- □ Cancer
- □ Anemia
- □ Blood transfusion
- □ Hyperlipidemia
- □ Hypercholesterolemia
- □ Deep vein thrombosis
- □ Hemochromatosis

Allergy/Immunologic
- □ Allergic rhinitis
- □ Fibromyalgia
- □ Hepatitis B
- □ Hepatitis C
- □ Tuberculosis
- □ MRSA
- □ HIV/AIDS
- □ VRE
- □ C.Difficile

OTHER: _____

PATIENT NAME AND DATE OF BIRTH: _____

Past Surgical History:

ENT
- □ M&T (ear tubes)
- □ Stapedectomy
- □ Septoplasty
- □ Rhinoplasty
- □ Rhytidectomy (face lift)
- □ Sinus surgery

Skin/Cardio/Resp
- □ Skin cancer removal
- □ AV fistula
- □ AV graft
- □ Port placement
- □ Aortic valve replacement
- □ Mitral valve replacement

Eyes/Gastro/GI
- □ Cataract
- □ Lens replacement
- □ Blepharoplasty
- □ Abdominal surgery
- □ Appendectomy
- □ Cholecystectomy (gall bladder)

MS/Neuro
- □ Back surgery
- □ Carpal tunnel
- □ Hip replacement
- □ Knee replacement
- □ Knee arthroscopy
- □ Kyphoplasty

ENT
- □ Adenoidectomy
- □ Tonsillectomy
- □ UP3
- □ Tracheotomy
- □ Thyroidectomy
- □ Parathyroidectomy
- □ Parotidectomy left
- □ Parotidectomy right
- □ Submandibular gland excision left
- □ Submandibular gland excision right
- □ Neck dissection left
- □ Neck dissection right

Skin/Cardio/Resp
- □ Pacemaker
- □ Vascular bypass
- □ Carotid endarterectomy
- □ CABG (heart bypass)
- □ Bronchoscopy
- □ Lung resection left
- □ Lung resection right

Eyes/Gastro/GI
- □ Colon resection
- □ Gastric bypass
- □ Hemorrhoidectomy
- □ Kidney removal
- □ TURP
- □ Prostatectomy (open)
- □ Hysterectomy
- □ Cesarean section
- □ D&C
- □ Tubal ligation

MS/Neuro
- □ Rotator cuff repair
- □ Interventional pain procedure
- □ Craniotomy/ brain surgery
- □ Amputation
- □ Brain tumor

OTHER SURGERIES: _____

For any surgeries you have undergone, did you have any of the following:

- □ **Anesthesia problem:** **Yes** **No**
- □ **Surgical complications:** **Yes** **No**
- □ **Post-Op delirium:** **Yes** **No**

OTHER: _____

PATIENT NAME AND DATE OF BIRTH: _____

Family History:

- □ Alcoholism
- □ Allergy
- □ Anesthesia problems
- □ Arthritis
- □ Asthma
- □ Bleeding disorder
- □ Breast cancer
- □ Cancer
- □ Head/Neck Cancer
- □ CVA/Stroke
- □ Depression
- □ Diabetes
- □ Hearing loss
- □ Heart disease
- □ Hypertension
- □ Hyperlipidemia
- □ Migraines
- □ Renal disease
- □ Seizures
- □ Skin cancer
- □ Suicide
- □ Thyroid disease

Social History

- □ Minor
- □ Single
- □ Married
- □ Divorced
- □ Separated
- □ Widowed
- □ Children - Yes, how many: _____
- □ Children - No
- □ Occupation: _____
- □ Lives alone - Yes
- □ Lives alone - No, with whom: _____
- □ History of domestic abuse
- □ Religion affecting care
- □ Immunizations current?
- □ Yes □ No □ Unknown

Tobacco Use:

Current Everyday Smoker: Y N
Former smoker: Y N
Calendar year started: _____
Calendar year quit: _____
Cigarettes: Y N Amount/week: _____
Cigars: Y N Amount/week: _____
Smokeless: Y N Amount/week: _____
Vape: Y N Amount/week: _____
Counseled to quit/cut down: Y N
Passive smoke exposure: Y N

Alcohol Use: Y N
If yes, type: _____
Drinks per day: _____
Drinks per year: _____
Drinks per week: _____
Counseled to quit/cut down: Y N
Comments: _____
_____

PATIENT NAME AND DATE OF BIRTH: _____

Review of Systems: (CHECK THE BOX NEXT TO THE CONDITION THE PATIENT IS ***CURRENTLY*** EXPERIENCING)

General
- □ Chills
- □ Fever
- □ Sweats
- □ Fatigue
- □ Weight loss

Eyes
- □ Loss of vision
- □ Double vision
- □ Blurred vision
- □ Eye pain
- □ Wear glasses/contacts

ENT
- □ Hearing loss right
- □ Hearing loss left
- □ Hearing loss both ears
- □ Hearing aids right
- □ Hearing aids left
- □ Hearing aids both ears
- □ Ear pain right
- □ Ear pain left
- □ Ear pain both ears
- □ Ear drainage right
- □ Ear drainage left
- □ Ear drainage both ears
- □ Ringing in ear right
- □ Ringing in ear left
- □ Ringing in ear both
- □ Nosebleeds right
- □ Nosebleeds left
- □ Nosebleeds bilateral
- □ Snoring
- □ Nasal congestion
- □ Nasal drainage/discharge
- □ Loss of smell
- □ Dental pain/problems
- □ Mouth sores
- □ Sore throat
- □ Hoarseness/voice change
- □ Difficulty swallowing

Cardiovascular
- □ Chest pain/discomfort
- □ Shortness of breath with exertion
- □ Palpitations
- □ Swelling hands/feet

Respiratory
- □ Cough
- □ Shortness of breath
- □ Coughing blood
- □ Wheezing

Gastrointestinal
- □ Heartburn/reflux
- □ Vomiting blood
- □ Nausea/vomiting
- □ Abdominal pain

Genitourinary
- □ Trouble starting/stopping urination
- □ Painful urination
- □ Bloody urine

Musculoskeletal
- □ Arthritis
- □ Arm pain
- □ Back pain
- □ Leg pain
- □ Joint swelling
- □ Joint pain

Skin
- □ Suspicious lesions
- □ Poor wound healing
- □ Skin cancer
- □ Rash

Neurologic
- □ Sensation of room spinning
- □ Poor balance
- □ Headaches
- □ Loss of coordination
- □ Numbness
- □ Speech difficulty
- □ Falling down
- □Seizures
- □ Fainting

Psychiatric
- □ Anxiety
- □ Depression
- □ Mental problems
- □ Suicidal thoughts

Endocrine
- □ Cold intolerance
- □ Heat intolerance
- □ Excessive hunger
- □ Excessive thirst

Heme/lymphatic
- □ Enlarged lymph nodes
- □ Easy bleeding or bruising
- □ Blood transfusion
- □ Cancer
- □ Anemia

Allergic/Immunologic
- □ Seasonal allergies
- □ Hives or rash
- □ Food allergies
- □ HIV exposure