

CENTRAL JERSEY OTOLARYNGOLOGY
General Medical History

Patient Name _____ Date of Birth _____ Age _____

1) Reason for visit _____

2) **FEMALE PATIENTS:** Are you currently pregnant yes no
 Attempting to become pregnant yes no
 Are you currently breast-feeding yes no

3) **Medical History** Do you have or have you had?

	yes	no		yes	no
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Regional Enteritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Hormone Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>

When was your last tetanus vaccine? less than 10 years ago more than 10 years ago
 If you are over 65, have you received the pneumonia vaccine? yes no
 Do you receive yearly flu shots? yes no

4) List all DRUG allergies _____

5) Do you have a LATEX allergy? yes no

6) List all current medications _____

Family Medical History _____
 (please list disease or illnesses prevalent in family)

Past Surgical History _____

Social History
 Use of alcohol never rarely moderate daily
 Use of tobacco never previously, but quit Current packs/per day _____

Please answer the following questions by checking yes or no:

CONSTITUTIONAL		EYES	
Good health generally	<input type="checkbox"/> yes no <input type="checkbox"/>	Blurred or double vision	<input type="checkbox"/> yes no <input type="checkbox"/>
Weight loss	<input type="checkbox"/> yes no <input type="checkbox"/>	Excess tearing	<input type="checkbox"/> yes no <input type="checkbox"/>
Weight gain	<input type="checkbox"/> yes no <input type="checkbox"/>		
Night sweats	<input type="checkbox"/> yes no <input type="checkbox"/>		
Excessive sleepiness	<input type="checkbox"/> yes no <input type="checkbox"/>		

CARDIOVASCULAR

Chest pain yes no
 Palpitations yes no

GENITOURINARY

Painful or frequent urination yes no
 Venereal disease (VD) yes no
 Venereal warts yes no
 Kidney stones yes no

NEUROLOGICAL

Weakness in arms or legs yes no
 Changes in coordination yes no
 Changes in balance yes no
 Shaking or tremors yes no
 Loss of consciousness yes no
 Passing out yes no
 Seizures or fits yes no
 Headaches yes no
 Numbness yes no

EARS

Hearing loss yes no
 Left ear yes no
 Right ear yes no

Dizziness yes no
 Spinning yes no
 Imbalance yes no
 Lightheadedness yes no

Pain yes no
 Left yes no
 Right yes no

NOSE/SINUSES

Drainage yes no
 Congestion yes no
 Facial pain yes no
 Bleeding yes no
 Diminished smell yes no
 Diminished taste yes no
 Sinusitis yes no
 Allergy symptoms yes no

RESPIRATORY

Shortness of breath yes no
 Cough yes no
 Coughing blood yes no

GASTROINTESTINAL

Nausea or vomiting yes no
 Constipation yes no
 Diarrhea yes no
 Vomiting blood yes no

MUSCULOSKELETAL

Bone or joint pain yes no
 Muscle pain yes no
 Muscle weakness yes no

SKIN

Itching or burning yes no
 Sores or rashes yes no

Ringling in ears yes no
 Left ear yes no
 Right ear yes no

Drainage yes no
 Left ear yes no
 Right ear yes no

THROAT

Difficulty swallowing yes no
 Hoarseness yes no
 Coughing up blood yes no
 Sore throat yes no
 Pharyngitis yes no

NECK

Swelling yes no
 Masses /lumps yes no
 Tenderness/pain yes no

DATE OF LAST PHYSICAL EXAMINATION _____

PATIENT UNABLE TO COMPLETE FORM _____

THIS FORM HAS BEEN REVIEWED WITH PATIENT

_____ M.D. _____ Date _____

_____ M.D. _____ Date _____