Midwest
EAR, NOSE & THROAT
SURGERY, PSC

MIDWEST EAR NOSE AND THROAT SURGERY

Welcome to our practice. Please help us update your information by completing this to the best of your ability.

Patient Name: _____ Date: _____

Referring Physician: _____

Current problem: _____

Length of problem: _____

Severity: circle one (mild) 1 2 3 4 5 (severe)

Where were you at the onset of this problem? _____

Does this pain/problem occur at a specific time? _____

What other associated problems have you been having? _____

What makes the problem worse or better? _____

Patient medical history:

Asthma/Lung Disease	No	Yes
Bleeding tendency	No	Yes
Cancer	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
High Blood Pressure	No	Yes
Seizures	No	Yes
Stroke	No	Yes

Previous Surgeries:

_____
_____
_____
_____
_____
_____
_____
_____

Patient social history:

Marital Status	No	Yes
Use of alcohol	No	Yes
Use of tobacco	No	Yes
Use of drugs	No	Yes
Exposure at home/work	No	Yes

Family medical history: (Diseases)

Mother: _____
Father: _____
Siblings: _____

Review of Systems: Please indicate any personal history below:

Eyes	No	Yes
Cardiovascular	No	Yes
Respiratory	No	Yes
Gastrointestinal	No	Yes
Genitourinary	No	Yes
Ears/Nose/Mouth/Throat	No	Yes
Hearing loss/ringing	No	Yes
Earache or drainage	No	Yes
Sinus probem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Musculoskeletal	No	Yes
Integumentary (skin, breast)	No	Yes
Neurological	No	Yes
Psychiatric	No	Yes
Endocrine	No	Yes
Hematologic/lymphatic	No	Yes

List all Allergies to Medications:

_____
_____
_____
_____
_____
_____
_____

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CURRENT MEDICATIONS

DATE:		DATE:	