McLaren Midland ENT **Candice C Colby, MD**

Date________________ Referring Physician_________________________________ Height______ Weight_______

Name____ Date of birth____________________________ Age________

REASON FOR TODAY"S VISIT:

____

____

PAST MEDICAL HISTORY

Do you have any of the following conditions?

High Blood Pressure	yes	no	COPD/Emphysema	yes	no	Thyroid Problems	yes	no
Heart Disease	yes	no	Asthma	yes	no	Stomach Problems	yes	no
Heart Attack	yes	no	Liver Problems	yes	no	Neurologic Problems	yes	no
Diabetes	yes	no	Kidney Problems	yes	no	Cancer type__________		

Other chronic illnesses or past illness/injuries?____

____

PAST SURGICAL HISTORY-Please list all past surgeries and year:

____

____

ANESTHESIA COMPLICATIONS? YES NO

CURRENT MEDICATIONS: (please include prescription and over the counter medications and amount of each):

____

____

____

DRUG ALLERGIES (please list drug allergy and reaction):

____

FAMILY HISTORY Please complete the following regarding your immediate family.

HAS ANY FAMILY MEMBER HAD ANY PROBLEMS WITH THE FOLLOWING:

	Family member (list who)		Family member (list who)
Ear disease	____________	Thyroid disease	____________
Hearing loss	____________	Allergies	____________
Cancer	____________	Musculoskeletal disease	____________
High Blood Pressure	____________	Bleeding	____________
Heart Disease	____________	Hematologic/lymphatic	____________
Stroke	____________	Neurological disease	____________
Anesthesia problems	____________	Diabetes	____________
Other:	____________		

OVER->

PERSONAL HISTORY:

Are you presently working? _______ Occupation: ______________________________

Marital Status ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Do you drink alcohol? _____ Amount consumed per WEEK: ________ Do you drink caffeine? _____ Amount consumed per DAY: ________

Have you ever used tobacco? ☐ Yes ☐ No, not currently ☐ Never
started (year): _______ quit (year): _______
how many/how much per day? ______________________________

Do you currently or have you ever used illicit drugs (marijuana, cocaine, meth)? _____

REVIEW OF SYSTEMS Please circle yes or no if you experience any of these problems:

CONSTITUTIONAL			CARDIOVASCULAR			ENDROCINE			RESPIRATORY		
Fever/Chills	yes	no	Chest pain	yes	no	Increased Appetite	yes	no	Wheeze	yes	no
Weight loss/Gain	yes	no	Irregular Pulse	yes	no	Decreased Appetite	yes	no	Cough	yes	no
Excessive Fatigue	yes	no	Tightness in chest	yes	no	Excessive thirst	yes	no	Coughing Blood	yes	no
Night sweats	yes	no	Swelling in Feet/Hands	yes	no	Hormone Problems	yes	no	Shortness of Breath	yes	no
EARS			**NOSE**			**THROAT**			**MUSCULOSKELETAL**		
Drainage from Ears	yes	no	Nosebleeds	yes	no	Sore Throats	yes	no	Joint Pain or Swelling	yes	no
Hearing loss	yes	no	Nasal Congestion	yes	no	Hoarseness	yes	no	Arm or leg weakness	yes	no
Ear Pain	yes	no	Nasal Drainage	yes	no	Difficulty swallowing	yes	no	Back Pain	yes	no
Ringing in Ears	yes	no	Sinus Headaches	yes	no	Mouth Sores	yes	no	Muscle Aches	yes	no
GASTROINTESTINAL			**EYES**			**NEUROLOGICAL**			**HEMATOLOGIC/LYMPHATIC**		
Indigestion	yes	no	Glaucoma	yes	no	Seizures	yes	no	Bleeding tendencies	yes	no
Nausea/Vomiting	yes	no	Cataracts	yes	no	Memory Problems	yes	no	Persistent swollen glands	yes	no
Diarrhea	yes	no	Double/Blurred Vision	yes	no	Speech Problems	yes	no	Night Sweats	yes	no
Constipation	yes	no	Vision Change	yes	no	Headache	yes	no	Easy Bruising	yes	no
Abdominal Pain	yes	no	Watery/Itchy Eyes	yes	no	Facial weakness	yes	no	Anemia	yes	no
PSYCHIATRIC			**GENITOURINARY**			**INTEGUMENTARY**			**ALLERGIC/IMMUNOLOGIC**		
Anxiety	yes	no	Difficulty Urinating	yes	no	Skin Rash	yes	no	Food Allergies	yes	no
Depression	yes	no	Painful Urination	yes	no	Sores	yes	no	Nasal Allergies	yes	no
Insomnia	yes	no	Blood in Urine	yes	no	Skin cancer	yes	no	Autoimmune Disease	yes	no

Other: ____________________

The information provided in this form is accurate to the best of my knowledge.

____
Patient Signature Date

____
Parent signature if patient is minor Date

I HAVE REVIEWED THE INFORMATION WITH PATIENT OR PARENT

____
Physician Date