



LAKE MICHIGAN



HEARING CENTER & SINUS and SLEEP APNEA CENTER

EAR, NOSE and THROAT Specialists

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Name: _____ Age: _____ DOB: _____ Sex: _____ Date: _____

Primary Care Physician: _____ City _____ Referring Physician: _____ City _____

Patient Occupation: _____ Employer: _____

Reason for Visit: _____

PLEASE LIST ALL YOUR CURRENT MEDICATIONS AND DOSAGES.

(Including over the counter medications, aspirin, vitamins and supplements)

Medication and Dose:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication allergies: Reaction? (rash, swelling, short of breath, etc.) _____ NONE

Allergic to LATEX? No Yes If yes, what is the reaction? _____

PATIENT MEDICAL HISTORY: (Please circle answers. Year of onset for those conditions that apply.)

Angina /chest pain	Patient	No Yes _____	Diabetes	Patient	No Yes _____	Asthma	Patient	No Yes _____
Irregular heartbeat -	No Yes _____	Stomach ulcers	No Yes _____	Tuberculosis	No Yes _____			
Heart attack	No Yes _____	Reflux	No Yes _____	Liver	No Yes _____			
High Cholesterol	No Yes _____	Thyroid	No Yes _____	Hepatitis	No Yes _____			
Heart valve problem	No Yes _____	Arthritis	No Yes _____	Stroke	No Yes _____			
High Blood Pressure	No Yes _____	Kidney	No Yes _____	Neuro/seizures	No Yes _____			
Disorder of blood cells	No Yes _____	Prostate	No Yes _____	COPD	No Yes _____			
Emphysema	No Yes _____	Easy bleeding/bruising	No Yes _____	HIV/AIDS	No Yes _____			
Allergy	No Yes _____	Endocrine	No Yes _____	Skin Disorder	No Yes _____			
Cancer	No Yes _____	(If yes, please indicate type of cancer) _____						
Other:	_____							

NAME: _____ DOB: _____ DATE: _____

PATIENT SURGICAL HISTORY AND DATES: _____ None

_____ Angioplasty/Stent	_____ Thyroidectomy	_____ Knee Repair
_____ Coronary bypass	_____ Adenoidectomy	_____ Gall Bladder
_____ Heart valve replacement	_____ Tonsillectomy	_____ Appendectomy
_____ Carotid Artery Surgery or Stent	_____ Nasal Surgery	_____ Hernia Repair
_____ Ear tubes	_____ Sinus surgery	_____ Prostate surgery
_____ Eardrum repair	_____ Upper GI Endoscopy	_____ Hysterectomy
_____ Mastoidectomy	_____ Hip Repair	_____ Pacemaker/Defibrillator (Make and Model)
_____ Other Surgery: _____		

Any Problems with anesthesia? No Yes If yes, what was the problem? _____

PATIENT SOCIAL HISTORY: (Past and/or Present)

History of noise exposure? No Yes (Circle type of exposure: Firearms/Military/Machinery/Music/other)

Exposure to second hand smoke? No Yes

Smoking History:	Currently/Past/Never	#Pack/Day _____	#Years _____	Quit in _____	(date/year/age)
Chewing Tobacco:	Currently/Past/Never	#Years _____		Quit in _____	(date/year/age)
Alcohol History:	Currently/Past/Never	#Drinks/Day _____	#Years _____	Quit in _____	(date/year/age)
Substance Use:	Currently/Past/Never	Type: _____		Quit in _____	(date/year/age)

FAMILY MEDICAL HISTORY: (Please circle answers. Immediate family only – parents, brothers or sisters)

	Family			Family			Family	
Angina /chest pain	No	Yes	Diabetes	No	Yes	Asthma	No	Yes
Irregular heartbeat -	No	Yes	Stomach ulcers	No	Yes	Tuberculosis	No	Yes
Heart attack	No	Yes	Reflux	No	Yes	Liver	No	Yes
High Cholesterol	No	Yes	Thyroid	No	Yes	Hepatitis	No	Yes
Heart valve problem	No	Yes	Arthritis	No	Yes	Stroke	No	Yes
High Blood Pressure	No	Yes	Kidney	No	Yes	Neuro/seizures	No	Yes
Disorder of blood cells	No	Yes	Prostate	No	Yes	COPD	No	Yes
Emphysema	No	Yes	Easy bleeding/bruising	No	Yes	HIV/AIDS	No	Yes
Allergy	No	Yes	Endocrine	No	Yes	Skin Disorder	No	Yes
Cancer	No	Yes	(If yes, please indicate type of cancer) _____					
Other:	_____							

This information is true and correct to the best of my knowledge.

Signature: _____ Date: _____
Patient/Parent/Guardian (circle one)

NAME: _____ DOB: _____ DATE: _____

REVIEW OF SYSTEMS

Please check the symptoms which you are experiencing **today**. If you have **none** of the following symptoms check here _____.

GENERAL: _____ fatigue, _____ fever, _____ loss of appetite, _____ pregnant

EYES: _____ tearing, _____ redness, _____ itchy eyes

EARS: _____ tinnitus (ringing in the ears), _____ vertigo (dizziness), _____ cerumen (wax in ears),
_____ earache, _____ drainage, _____ hearing loss

NOSE AND SINUSES: _____ nasal itch, _____ nasal discharge, _____ nosebleed, _____ sneezing, _____ post nasal drip,
_____ trauma, _____ sinusitis, _____ facial pain/pressure, _____ congestion

MOUTH AND THROAT: _____ toothache, _____ dentures, _____ bleeding gums, _____ problems swallowing,
_____ hoarseness, _____ soreness, _____ sore tongue, _____ growths, bumps or lumps

NECK: _____ pain on motion, _____ restricted range of motion, _____ swollen glands, _____ lumps, _____ pain,
_____ goiter, _____ tender to touch

BREASTS: _____ discharge, _____ lump, _____ pain

RESPIRATORY: _____ cough, _____ wheezing, _____ shortness of breath

CARDIAC: _____ chest pain on exertion, _____ irregular pulse, _____ palpitations (abnormal rapid or irregular heart
beat), _____ rapid pulse, _____ slow pulse

GASTROINTESTINAL: _____ abdominal pain, _____ nausea, _____ problems swallowing, _____ indigestion,
_____ heartburn, _____ diarrhea, _____ constipation

LYMPH NODES: _____ enlargement, _____ tenderness If yes, what location? _____

MUSCULOSKELETAL: _____ joint pain, _____ backache, _____ skin rash or dryness, _____ muscle aches or weakness
_____ leg cramps, _____ "crawling" leg sensation

NEUROLOGIC: _____ migraine, _____ tension headache, _____ faint, _____ seizure, _____ weakness,
_____ lightheaded

PSYCHIATRIC: _____ anxiety, _____ insomnia, _____ irritable/crying

ENDOCRINE: _____ cold/heat intolerance, _____ excessive thirst, _____ excessive urination

HEMATOLOGY/ONCOLOGY: _____ easy bleeding, _____ easy bruising, _____ frequent infections

NEW PATIENT REFERRAL

Date of Referral: _____ Staff Initials: _____ Appointment Date: _____ Time: _____ Paperwork Mailed: _____

PATIENT INFORMATION

Patient Name: _____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Other Phone: _____

Date of Birth: _____ Marital Status: _____

Social Security #: _____ Sex: M/F

Patient Relationship to Responsible Party: _____

Patient's Employer: _____ Phone: _____

Primary Care Physician: _____ Referring Physician: _____

RESPONSIBLE PARTY INFORMATION

Resp. Party Name: _____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Other Phone: _____

Social Security #: _____ Sex: M/F

Resp. Party Employer: _____ Phone: _____

INSURANCE

PRIMARY INSURANCE COMPANY: _____ Phone: _____

Subscriber's Name: _____
LAST FIRST MIDDLE

Patient Relationship to Subscriber: _____ Date of Birth: _____

Subscriber's Employer: _____ Phone: _____

Contract (ID) Number: _____ Group #: _____

SECONDARY INSURANCE COMPANY: _____ Phone: _____

Subscriber's Name: _____
LAST FIRST MIDDLE

Patient Relationship to Subscriber: _____ Date of Birth: _____

Subscriber's Employer: _____ Phone: _____

Contract (ID) Number: _____ Group #: _____