Lake Norman
Ears, Nose & Throat
Piedmont HealthCare

Today's date:_____ Name:_____ DOB:_____

If you have a current medication list with you please provide it to clinical staff

Medications Prescriptions, vitamins, over the counter	**Milligram strength of the pills**	**How many times of day you take your pills**

Please let staff know if you need additional pages to list medications

Medication Allergies	
Medication	**Reaction**

Health Habits		
	Yes/No	**Circle all that apply**
Tobacco		Cigarettes Cigars Chewing Tobacco Current ___yes ___no, if yes How much a day_____ for how many years_____ Former ___yes ___no, if yes How much a day____ for how many years_____ year quit_____
Alcohol		Beer Wine Liquor Current ___yes ___no, if yes How much a day/month/year_____ for how many years_____ Former ___yes ___no, if yes How much a day/month/year _____ for how many years_____
Caffeine		
Recreational Drugs		
Other		

Surgeries	
Year	**Procedure**

Indicate Which Apply to You					
General		**Eyes**		**Nose and Throat**	
Weight change		Glaucoma		Nasal stuffiness/ drainage	
Appetite/ thirst change		Vision changes		Frequent nosebleeds	
Excessive fatigue/nervousness		Red/itchy, watery eyes		Sore throat	
Difficulty sleeping		Eye pain		Mouth sores/ ulcers	
Enlarged/tender lymph nodes or glands		Do you wear glasses/ contacts		Sleep apnea (stop breathing while sleeping)	
Ears		Dry eyes		Teeth/ gum problems	
Infections		**Pulmonary**		Snoring	
Hearing loss		Shortness of breath		Hoarseness	
Earaches		Difficulty breathing		**Cardiovascular**	
Ear drainage		Cough-dry/ productive		Heart attack/ failure/ angina	
Buzzing/ ringing		Asthma/ wheezing		Chest pain. Tightness	
Feel “stopped up”		Night sweats		Irregular heart beats	
Gastrointestinal		Lung cancer		High blood pressure	
Heartburn/ indigestion		Fever/ chills		Swelling of feet/ ankles	
Difficulty swallowing		**Musculoskeletal**		Leg cramps with walking	
Stomach pains/ ulcers		Joint pain/ tenderness		Mitral Valve/ Murmur	
Nausea/ vomiting		Joint swelling/ warmth		**Skin**	
Loose stool/ diarrhea		Joint stiffness		Rashes	
Constipation		Muscle pain		Dry/ itchy skin	
Liver problems		Back/ neck pain		Bruising	
Gallstones		Weakness		Mole/ lesion changes	
Neurologic		Prone to falls		Skin color changes	
Headaches/ migraines		**Psychiatric**		Hair/ nail problems	
Dizziness/ nausea		Anxiety		Skin growths	
Fainting/ blackouts		Depression		**Males Only**	
Paralysis		Suicidal thoughts		Prostate problems	
Seizures/ convulsions		Overly emotion/ mood swings		Venereal disease	
Coordination problems		Phobias		**Females Only**	
Other		**Other**		Pregnant	
				Venereal disease	
				Do you use birth control	

Family History					
Check if, your blood relatives had any of the following:					
	Disease:	**Relationship:**		**Disease:**	**Relationship:**
	Lung disease			Kidney Disease	
	Stroke			High Blood Pressure	
	Cancer			Bell’s Palsy	
	Liver Disease			Arthritis	
	Diabetes			Hearing loss	
	Heart Disease			Shingles	
	Thyroid			Bleeding Disorder	
	Other				

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