LAKE GROVE ENT | EAR NOSE & THROAT

Maureen Mulcahy, MD • Robert Furman, MD • Caroline Yang, MD • Erika Schettler Huberty, MD
Michelle Vessely, MD • Kimberly Lavoie, AuD, CCC-A • Lisa Bell, AuD, CCC-A

Adult Health History

Patient Name: _____ Date of Birth: _____ Age: _____

Today's Date: _____ Doctor you are seeing today: _____

How did you hear about our practice? _____

Height: _____ Weight: _____ Sex: ☐ M ☐ F

What is the primary reason for your visit with the doctor today?_____

_____

Do you have a:

Latex Allergy ☐ Yes ☐ No

Drug Allergy ☐ Yes ☐ No

If yes, please list medications and reactions: _____

_____

Medications

Please list any medications that you take on a regular basis. Include medication name, dose, and frequency.

_____

_____

Past Medical History

Do you have any medical problems? ☐ Yes ☐ No

Please list:_____

_____

_____

_____

Have you ever had cancer? ☐ Yes ☐ No

If so, what type? _____

Past Surgical History

Have you ever had surgery? ☐ Yes ☐ No

Please list type and approximate date: _____

_____

_____

Family History: Any family history of the following? If yes, please list family member's relation to you:

Heart Disease	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Bleeding tendencies	☐ Yes	☐ No	_____
Other _____			_____

Habits:

Do you drink alcohol?	☐ Yes	☐ No	If yes, how many drinks per week? _____
Do you currently use illicit drugs?	☐ Yes	☐ No	If yes, what drugs? _____
Have you ever used tobacco products?	☐ Yes	☐ No	If yes, for how many years? _____
			If yes, how many packs per day? _____
Have you stopped?	☐ Yes	☐ No	If yes, what date or how long ago? _____

Review of Systems: Do you currently have any of the following symptoms?

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Lethargy	☐ Yes	☐ No
Weight gain/loss	☐ Yes	☐ No

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No

Respiratory

Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No

Neurological

Dizzy spells	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No

Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No

Hematological/Lymphatic

Blood clotting problem	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Swollen nodes	☐ Yes	☐ No
History of a blood transfusion	☐ Yes	☐ No
History of Hepatitis	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No

Allergic/Immunologic

Itchy eyes/nose	☐ Yes	☐ No
Runny nose	☐ Yes	☐ No
Pets in the home	☐ Yes	☐ No
Immune disorder	☐ Yes	☐ No

Pharmacy you prefer to use: _____

Location: _____