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A Lexington Medical Center Physician Practice

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Lexington-ENT.com

PATIENT INFORMATION

Patient Name: ____

Date: ____

REVIEW OF SYMPTOMS

Are you **CURRENTLY** having any of the symptoms listed below?

1. Constitutional:
- Fever: ☐ Yes ☐ No
- Chills: ☐ Yes ☐ No
- Sweats: ☐ Yes ☐ No

2. Eyes:
- Sudden Loss of Vision: ☐ Yes ☐ No
- Changes in Vision: ☐ Yes ☐ No
- Eye Pain: ☐ Yes ☐ No

3. Ear, Nose, Throat:
- Tinnitus: ☐ Yes ☐ No
- Difficulty Swallowing: ☐ Yes ☐ No
- Painful Swallowing: ☐ Yes ☐ No
- Hearing Loss: ☐ Yes ☐ No

4. Cardiovascular:
- Chest Pain: ☐ Yes ☐ No

5. Respiratory:
- Shortness of Breath: ☐ Yes ☐ No
- Difficulty Breathing: ☐ Yes ☐ No

6. Gastrointestinal:
- Reflux Symptoms: ☐ Yes ☐ No
- Stomach Pain: ☐ Yes ☐ No

7. Allergy:
- Nasal Congestion / Drainage: ☐ Yes ☐ No
- Itchy Watery Eyes: ☐ Yes ☐ No
- Sneezing: ☐ Yes ☐ No
- Frequent Sinus Infections: ☐ Yes ☐ No

8. Endocrine:
- Thyroid Problems: ☐ Yes ☐ No
- Under-active Thyroid: ☐ Yes ☐ No
- Thyroid Nodules: ☐ Yes ☐ No
- Enlarged or Swollen Lymph Nodes: ☐ Yes ☐ No
- Bleeding problems: ☐ Yes ☐ No

9. Neurological:
- Headache: ☐ Yes ☐ No
- Migraine: ☐ Yes ☐ No

10. Integumentary:
- Skin Rashes and/or Outbreaks: ☐ Yes ☐ No

11. Tobacco Use: ☐ Yes ☐ No

12. Former Tobacco Use: ☐ Yes ☐ No

13. Alcohol Use: ☐ Yes ☐ No

Physician Signature: ______________________________ Date: ______________

Patient Name: ______________________________ DOB: ______________

Referring Physician: ______________________________ Date of visit: ______________

Medication Allergies: ______________________________

Preferred Pharmacy: ______________________________ Pharmacy Phone Number: ______________

Pharmacy Address: ______________________________

What is the reason you are here today? ______________________________

____

How has this problem been treated so far? ______________________________

____

Have you had any testing done yet? ☐ CT Scan ☐ MRI ☐ Allergy Test ☐ Hearing Test

PAST MEDICAL/SURGICAL HISTORY (Have you ever had the following?):

MEDICAL HISTORY

☐ None

☐ Heart Disease	Date: ______	☐ Asthma	Date: ______
☐ Diabetes	Date: ______	☐ Depression	Date: ______
☐ Hepatitis	Date: ______	☐ Kidney Stones	Date: ______
☐ Headaches	Date: ______	☐ Blood Transfusions	Date: ______
☐ Stroke	Date: ______	☐ GERD/Reflux	Date: ______
☐ HIV/AIDS	Date: ______	☐ Radiation Therapy	Date: ______
☐ Cancer	Date: ______	☐ Thyroid Disease	Date: ______
☐ Bleeding Disorder	Date: ______	☐ Seasonal Allergy	Date: ______

SURGICAL HISTORY

☐ None

☐ Heart Valve	Date: ______	☐ Ear Surgery	Date: ______
☐ Cardiac Cath.	Date: ______	☐ Septoplasty	Date: ______
☐ Angioplasty/Stent	Date: ______	☐ Thyroid Surgery	Date: ______
☐ Cardiac Surgery	Date: ______	☐ Sinus Surgery	Date: ______
☐ Ear Tubes	Date: ______	☐ Tonsillectomy	Date: ______
☐ Cosmetic Surgery	Date: ______	☐ Adenoidectomy	Date: ______
☐ Cataract Surgery	Date: ______	☐ Neck Surgery	Date: ______

Other Illnesses: ______________________________

____

Other Surgeries: ______________________________

____

Have you ever been on allergy shots? ☐ Yes ☐ No   If yes, did they help your symptoms? ☐ Yes ☐ No

Do you currently take any medications? ☐ Yes ☐ No (If yes, please list medications below)

MEDICATION	DOSE	HOW OFTEN?	MEDICATION	DOSE	HOW OFTEN?

Patient Signature: ______________________________ Date: ______________