



Allergy, Ear, Nose & Throat
Associates of Texas
Tariq M. Yunus, MD

PATIENT NAME _____

DATE _____

PATIENT HISTORY AND REVIEW OF SYSTEMS

PAST MEDICAL HISTORY Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia/Bulimia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma/Bronchitis	<input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts/Glaucoma <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney/Liver Disease	<input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> STD <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers
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SOCIAL HISTORY Check (✓) and describe all that apply.

Alcohol: Type _____ Amount _____ Frequency _____
 Antacids: Type _____ Used For: _____ Frequency _____
 Tobacco Use: Type _____ Amount Daily _____ How long _____
 Caffeine: Type _____ Amount Daily _____
 Exercise: Regularly Yes No Activity _____ Frequency _____
 Sleep: Difficulty falling asleep Frequent awakenings Early morning awakening Snoring Daytime drowsiness

FAMILY HISTORY Please explain Whom in your family has the following.

Diabetes: _____ **Cancer:** _____ **Thyroid Disease:** _____

PAST SURGERIES AND HOSPITALIZATIONS (with year of occurrence).

CURRENT MEDICATIONS

ALLERGIES TO MEDICATIONS

REASON FOR VISIT

REVIEW OF SYSTEMS Check (✓) symptoms you currently have or recently had.

<p>EYES</p> <input checked="" type="checkbox"/> Eye disease or injury <input checked="" type="checkbox"/> Vision changes <input checked="" type="checkbox"/> Wear glasses/contact lenses <p>EAR, NOSE, THROAT</p> <input checked="" type="checkbox"/> Bleeding gums <input checked="" type="checkbox"/> Tongue Problems <input checked="" type="checkbox"/> Difficulty swallowing <input checked="" type="checkbox"/> Earache <input checked="" type="checkbox"/> Ear discharge <input checked="" type="checkbox"/> Hay fever or allergies <input checked="" type="checkbox"/> Hearing loss <input checked="" type="checkbox"/> Hoarseness <input checked="" type="checkbox"/> Lump in the neck <input checked="" type="checkbox"/> Mouth sore <input checked="" type="checkbox"/> Nasal discharge <input checked="" type="checkbox"/> Nasal stuffiness <input checked="" type="checkbox"/> Neck pain <input checked="" type="checkbox"/> Nose bleeding <input checked="" type="checkbox"/> Cough <input checked="" type="checkbox"/> Ringing in ears <input checked="" type="checkbox"/> Sinus problems <input checked="" type="checkbox"/> Snoring <input checked="" type="checkbox"/> Sore throat	<p>GENERAL</p> <input checked="" type="checkbox"/> Chills <input checked="" type="checkbox"/> Fainting or Dizziness <input checked="" type="checkbox"/> Fatigue <input checked="" type="checkbox"/> Fever <input checked="" type="checkbox"/> Headache <input checked="" type="checkbox"/> Loss of appetite <input checked="" type="checkbox"/> Loss of weight <input checked="" type="checkbox"/> Sweats <p>CARDIOVASCULAR</p> <input checked="" type="checkbox"/> Chest pain <input checked="" type="checkbox"/> High or low blood pressure <input checked="" type="checkbox"/> Irregular or rapid heart beat <input checked="" type="checkbox"/> Poor circulation <input checked="" type="checkbox"/> Varicose veins <p>RESPIRATORY</p> <input checked="" type="checkbox"/> Spitting up blood <input checked="" type="checkbox"/> Shortness of breath <input checked="" type="checkbox"/> Asthma or Wheezing <p>GENITO-URINARY</p> <input checked="" type="checkbox"/> Blood in urine <input checked="" type="checkbox"/> Frequent or painful urination <input checked="" type="checkbox"/> Lack of bladder control	<p>GASTROINTESTINAL</p> <input checked="" type="checkbox"/> Black or tarry stools <input checked="" type="checkbox"/> Change in bowel movements <input checked="" type="checkbox"/> Constipation <input checked="" type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Excessive hunger or thirst <input checked="" type="checkbox"/> Indigestion or heartburn <input checked="" type="checkbox"/> Loss of appetite <input checked="" type="checkbox"/> Nausea or vomiting <input checked="" type="checkbox"/> Stomach pain <input checked="" type="checkbox"/> Vomiting blood <p>MUSCLE/JOINT/BONE</p> <p>Pain, weakness, numbness in:</p> <input checked="" type="checkbox"/> Arms or Legs <input checked="" type="checkbox"/> Back or Body <input checked="" type="checkbox"/> Joints <p>NEUROLOGICAL</p> <input checked="" type="checkbox"/> Tremors <input checked="" type="checkbox"/> Paralysis <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Head injury	<p>ENDOCRINE</p> <input checked="" type="checkbox"/> Glandular or hormone problem <input checked="" type="checkbox"/> Thyroid disease <input checked="" type="checkbox"/> Diabetes (insulin or non insulin) <input checked="" type="checkbox"/> Change in hat or glove size <p>HEMATOLOGIC/LYMPHATIC</p> <input checked="" type="checkbox"/> Slow to heal after cuts <input checked="" type="checkbox"/> Bleeding or bruising tendency <input checked="" type="checkbox"/> Anemia <input checked="" type="checkbox"/> Phlebitis <input checked="" type="checkbox"/> Past transfusion <p>SKIN</p> <input checked="" type="checkbox"/> Change in hair or nails <input checked="" type="checkbox"/> Hives <input checked="" type="checkbox"/> Itching <input checked="" type="checkbox"/> Rash <input checked="" type="checkbox"/> Scars <input checked="" type="checkbox"/> Sore that won't heal <p>Date of last physical exam _____</p> <p>Are you pregnant? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
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