Three Rivers Ear, Nose & Throat (A Division of Proliance Surgeons)
Patient Profile

Name: ____ Date of Birth: ______________ Today's Date: ___________

☐ Male ☐ Female Primary care doctor_______________________ Referring doctor _______________________________

Drug Allergies

Allergy	Type of reaction

Current Medications — List prescription, over-the-counter, and herbal meds

Name of Medication	Dose and number of times per day

Past Medical History

Do you or have you had:	Yes	No	If "yes", please describe
Abdominal problems			(i.e., ulcers, GE reflux)
Allergies			If so, to what and what was the reaction?
Have you required allergy shots?			
Arthritis			
Bleeding disorders			
Cancer (what type?)			
Contagious disease			
AIDS			
Hepatitis			A B C
Tuberculosis			
Venereal disease			
Diabetes			
Eye disease			(ie, glaucoma)
Head or facial injuries			
Hearing loss			
Heart problems			
Heart attack			
High blood pressure			
Kidney problems			
Liver problems			(ie, cirrhosis)
Lung problems			(ie, asthma, emphysema)
Neurologic problems			(ie, seizures)
Psychiatric problems			(ie, depression, anxiety disorder)
Stroke			
Thyroid problems			
Urologic problems			(ie, prostate, urinary)

Please list any other medical problems: ____

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Are you immunizations up to date? ☐ yes ☐ no If no, explain: ____

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Patient Profile (continued)

Name: ____ Today's Date: __________________ _

Prior Surgeries

Type of surgery	Approximate date

Prior Hospitalizations

Reason	Approximate date

Family History

	yes	no	Relationship (mom, dad, grandparent, sibling, etc.)	maternal	paternal
Cancer (and type if known)					
Hearing loss					
Anesthesia problems					
Bleeding problems					
Lymphoma					
Leukemia					

Social History

Family members in household: Children ___________ Others:_________________________________
Smoking: Packs per day ____________ and for how long? _______ Former smoker?___ Year you quit__ ______
Chewing tobacco: How much _________ and for how long?__________________
Smokers in the household? Yes____ No____
Alcohol use: Type________ how much _________ and for how long? _________________
Recreational or I.V. drug use: What type? ____________ and for how long? ____________
Pets in the house? Yes ____ No____ Type(s): ____

Are you currently experiencing any of the following?

- ☐ Fever
- ☐ Chills
- ☐ Recent weight loss
  How much? ___Over how long?____
- ☐ Recent weight gain
  How much?____ Over how long?_____
- ☐ Blurred vision
- ☐ Decreased hearing
- ☐ Ear ringing
- ☐ Ear pain
- ☐ Difficulty breathing through nose
- ☐ Nose bleeding
- ☐ Nose drainage
- ☐ Throat pain
- ☐ Difficulty swallowing
- ☐ Neck mass or lump
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Chest pain
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Reflux of acid
- ☐ Bleeding problems
- ☐ Easy bruising
- ☐ Unusually cold
- ☐ Unusually hot
- ☐ Unusually fatigue
- ☐ Rash
- ☐ Daytime sleepiness
- ☐ Localized weakness
- ☐ Numbness Where?_______________
- ☐ Unusually anxious
- ☐ Increased stress
- ☐ Trouble urinating
- ☐ Joint pain Where? _______________

Additional Information: Please list any further information or details from the questionnaire here: _____ _________________________

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