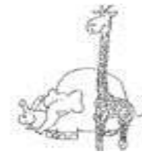
Robert C. McLean, M.D., Ph.D.
Stacie S. Morgan, M.D.
Amber M. Price, M.D.
Geoffrey L. Wright, M.D.

Panhandle Ear, Nose & Throat



Patient / Family History

Although we primarily treat the area of ear, nose and throat, your ear, nose and throat are part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care you will receive. Please circle all the answers that apply to each question. Thank you for answering the following questions.

Appointment Date: ___________________________ **MR #** _________________________

Patient Name: ____ **Patient Date of Birth:** ____________

Were you referred to our office by? Family Friend Patient Television Phone Book Web Site Physicians
Referred by Dr. ____

Where were you seen: Baptist St. Anthony's Northwest Texas Hospital Other:_________________________

What problem(s) are you here for today? Ears Nose Throat Voice Hearing Hearing Aids

What symptoms are you here for today? ____

____

Are you allergic to any medications? Anesthetics Aspirin Codeine Penicillin Sulfa Latex None

Other:____

Please list all Medications and dosage you are taking: ALL PRESCRIBED AND OVER THE COUNTER MEDICINES

_______________________ _____________________________ _____________________________

_______________________ _____________________________ _____________________________

_______________________ _____________________________ _____________________________

Please review the following and place a check mark next to what applies:

Constitutional:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats

Respiratory:
- ☐ Apnea during sleep
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Wheezing

Genitourinary:
- ☐ Change in urine color
- ☐ Dysuria (painful urination)
- ☐ Urinary frequency

Neurological:
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Excessive daytime sleepiness
- ☐ Non-restorative sleep
- ☐ Numbness in extremities
- ☐ Syncope (fainting)
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness

HEENT:
- ☐ Blurred vision
- ☐ Choking on liquids
- ☐ Choking on solids
- ☐ Diplopia (double vision)
- ☐ Drooling
- ☐ Dysphagia (difficulty swallowing)
- ☐ Ear drainage
- ☐ Hoarseness
- ☐ Mouth ulcers
- ☐ Otalgia (earache)
- ☐ Pharyngitis (sore throat)
- ☐ Tinnitus (ringing in the ears)
- ☐ Visual changes
- ☐ Hearing loss

Cardiovascular:
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Palpitations

Metabolic/Endocrine:
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Increased thirst

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Vomiting

Musculoskeletal:
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

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Appointment Date: ___________________________ **MR #** _________________________

Patient Name: ____ **Patient Date of Birth:** ____________

List general medical problems:____

____

Patient Medical History:

- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood Transfusion
- ☐ Cancer Type__________________
- ☐ Cleft lip
- ☐ Cleft Palate
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ GERD
- ☐ Headaches
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Otitis Media
- ☐ Otosclerosis
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Tinnitus (ringing in the ears)
- ☐ Vertigo

List All Past Surgeries:

________________________________ ________________________________ ________________________

________________________________ ________________________________ ________________________

________________________________ ________________________________ ________________________

Have you had any recent diagnostic test such as: Barium Swallow Cat Scan MRI X-rays Biopsy Hearing Test

Other_____________________How long ago?_____________ Where was the test performed?_______________

Family History *(please indicate relationship next to disease: i.e. Mom, Dad, Brother, Sister, Aunt, Uncle, Cousin, Child)*

Allergies __________________________________
Asthma___________________________________
Autoimmune disease________________________
Blood disorder_____________________________
Cancer___________________________________
Chronic ear infections_______________________
Cleft lip/palate_____________________________
Coronary Artery Disease______________________
Deafness_________________________________
Diabetes__________________________________

GERD_____________________________________
Meniere's disease___________________________
High blood Pressure_________________________
Migraines_________________________________
Obesity__________________________________
Renal disease______________________________
Seizures__________________________________
Sickle Cell disease_________________________
Stroke___________________________________
Thyroid disorder____________________________

Social History:

Have you ever smoked? Yes No **Current** Packs per day? ¼ ½ 1 1 ½ 2 **I Quit** When?______

Do you use smokeless tobacco or chewing tobacco? Yes No How many cans per day? ¼ ½ 1 1 ½ 2 2 ½

Do you consume alcoholic beverages? Yes No What quantity and how frequent? ____________________

Do you use recreational drugs? Yes No If Yes, what type, what quantity and how frequent?_____________

Preferred Pharmacy: ____

Name, Address and Phone