DeFatta
ENT & ALLERGY

# ENT HEALTH SCREENER(13+)

Name_____

Date of Birth_____

Chief Complaint _____

Preferred Pharmacy _____

Primary/Referring Doctor_____

Date of Visit _____

Height_____

Weight_____

Temperature_____

Blood Pressure _____

Pulse_____Resp. _____

**If you or anyone you know has any of the health concerns mentioned below, please give us a call. We would be happy to answer questions regarding our clinical services.**

## SINUS OR ALLERGY CONCERNS?

- ☐ Have you had sinus infections, pressure or headaches?
- ☐ Do you suffer from seasonal allergies?
- ☐ Do you have congestion or difficulty breathing through your nose?

## SLEEP OR SNORING CONCERNS?

- ☐ Has anyone ever told you that you snore?
- ☐ Have you ever been told you stop breathing in your sleep or wake up gasping?
- ☐ Do you wear recommended CPAP but cannot tolerate it?

## COSMETIC CONCERNS?

- ☐ Do you wish to enhance your appearance by removing facial lines, folds and wrinkles?
- ☐ Are you interested in achieving a younger or fresher look?
- ☐ Do you wish you could eliminate stubborn, unwanted fat?

## PEDIATRIC CONCERNS?

- ☐ Is your child suffering from frequent ear infections?
- ☐ Does your child have trouble sleeping through the night?
- ☐ Does your child sneeze, cough or have constant nasal drainage?

## HEARING OR COMMUNICATION CONCERNS?

- ☐ Have you had your hearing tested in the last year?
- ☐ Have you noticed situations where it's difficult to follow conversations?
- ☐ Have you noticed a change in your hearing over the past year?

## VOICE & SWALLOWING CONCERNS?

- ☐ Have you experienced any hoarseness, voice pain/fatigue or other changes in your voice?
- ☐ Do you have soreness, tightness, voice pain or other difficulty when swallowing?

**PLEASE COMPLETE BACKSIDE OF FORM.**

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**Circle all symptoms that you are experiencing currently:**

| | | | |
|---|---|---|---|
| **Fatigue** | Ear Drainage | Trouble/Pain Swallowing | Headache |
| Vomiting | Sinus Pain | Too Hot/Too Cold | Nausea |
| Blurry Vision | Heart Palpitations | Joint Pain | Double Vision |
| **Ringing in Ears** | Anorexia | Lightheadedness | **Hearing Loss** |
| Nasal Passage Blockage | Excessive Thirst | Recent Weigh Loss | Nasal Discharge |
| Chest Pain | Neck Pain | Eye Pain | Hoarseness |
| Coughing up Blood | Skin Rash | Ear Pain | Cough |
| Blood in Feces | Chills | Nosebleeds | Abdominal Pain |
| Lymph Node Enlargement | Frequently Sick | Neck Mass | Clotting Problems |
| Moles/Discolored Spots | Itchy Eyes | Wheezing | Persistent Itch |
| Fever | **Dizziness** | Heartburn | Tremors |
| Sneezing | Sore Throat | Bleeding Problems | |
| Watery Eyes | Difficulty Breathing | Back Pain | |

| **Medications You Are Taking Now and Dose (if known)** | | | |
|---|---|---|---|
| Name of Drug | Dose of Drug | Name of Drug | Dose of Drug |
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |
| Drug Allergies & Resulting Reactions: | | | |
| Medical History: | | | |
| Surgical History: | | | |
| Family History: | | | |

| | |
|---|---|
| Current smoker or tobacco user? ☐ Yes ☐ No<br>History of smoking or tobacco use? ☐ Yes ☐ No<br>Any exposure to 2nd hand smoke? ☐ Yes ☐ No<br>Drug Use? ☐ Yes ☐ No What? _____<br>Marital Status:<br>☐ Married ☐ Single ☐ Widowed ☐ Divorced | Drink Caffeine? ☐ Yes ☐ No<br>Drink Alcohol? ☐ Yes ☐ No<br>Exercise Regularly? ☐ Yes ☐<br>No Lives in a Nursing Home? ☐ Yes ☐<br>No Work:<br>☐ Full time ☐ Part time ☐ Retired ☐ Unemployed |

Physician Signature_____ Date_____