DeFatta
ENT & ALLERGY

ENT HEALTH SCREENER(0-1)

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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DeFatta ENT & ALLERGY

Circle all symptoms that you are experiencing currently:

Fatigue	Fever	Chills	Frequently Sick
Vomiting	Vomiting	Sneezing	Nosebleeds
Ear Pain	**Hearing Loss**	Ear Drainage	Sore Throat
Nasal Discharge	Nasal Passage Blockage	Snoring	Difficulty Breathing
Neck Mass	Hoarseness	**Speech Delay**	Cough
Difficulty Eating	Wheezing	Noisy Breathing	Constipation
Swallowing Problems	Abdominal Pain	Diarrhea	Neck Pain
Bleeding Problems	Clotting Problems	Lymph Node Enlargement	Persistent Itch
Joint Pain	Back Pain	Decrease in Strength	Headache
Moles/Discolored Spots	Skin Rash	Difficult with Balance	Daytime Sleepiness
Fainting	Seizure	**Delayed Milestones**	
Insomnia	Fussy Infant	Recent Weight Loss	

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:			
Any exposure to 2nd hand smoke? ☐ Yes ☐ No Immunizations up to date? ☐ Yes ☐ No Car seats/seatbelts used? ☐ Yes ☐ No		Currently in daycare? ☐ Yes ☐ No Lives with parents? ☐ Yes ☐ No Lives with foster parents? ☐Yes ☐No	

Physician Signature_____ Date_____