DeFatta
ENT & ALLERGY

ENT HEALTH SCREENER(2-12)

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	Nosebleeds	Wheezing	Headache
Vomiting	Sore Throat	Diarrhea	Anxiety
Blurry Vision	Heart Murmur	Neck Pain	Nausea
Ear Drainage	Abdominal Pain	Skin Rash	Double Vision
Sinus Pain	Lymph Node Enlargement	**Delayed Milestones**	Hearing Loss
Difficulty Breathing	Moles/Discolored Spots	Recent Weight Loss	Snoring
Trouble/Pain Swallowing	Seizure	Eye Pain	Speech Delay
Persistent Itch	Insomnia	Ear Pain	Cough
Fainting	Chills	Nasal Passage Blockage	Bleeding Problems
Daytime Sleepiness	Frequently Sick	Hoarseness	Back Pain
Fever	Itchy Eyes	Noisy Breathing	Difficulty with Balance
Sneezing	Nasal Discharge	Constipation	Depression
Watery Eyes	Neck Mass	Joint 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:			

Caffeine Use?	☐ Yes ☐ No	Currently in school?	☐ Yes ☐ No
Any exposure to 2nd hand smoke?	☐ Yes ☐ No	Currently in daycare?	☐ Yes ☐ No
Car seats/seatbelts used?	☐ Yes ☐ No	Lives with parents?	☐ Yes ☐ No
Exercise Regularly?	☐ Yes ☐ No	Lives with foster parents?	☐Yes ☐No

Physician Signature____Date____________