David Greene, MD
Board Certified
Ear, Nose & Throat
Facial Plastic & Reconstructive Surgery
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*Patient Name*_____

Today's Date _____/_____/_____

Age _____ *Sex: Male / Female*

*Date of Birth*_____/_____/_____ *V2.15.18*

MEDICAL HISTORY QUESTIONNAIRE

Primary Care Provider_____ **Referring Physician**_____

VISIT TYPE: □ *Consultation*: referred/sent to see Dr. Greene by a Doctor, or other healthcare provider.
□ *New Patient Visit:* came on your own. □"New Again*": you saw Dr. Greene MORE THAN 3 years ago.*

HOW DID YOU FIND US? □Referral, □ Word of mouth, □Internet, □Newspaper, □Website, □Healthgrades, □Vitals, □Other_____

CHIEF COMPLAINT: (MAIN reason for today's visit): _____

_____

_____

HISTORY OF THE PRESENT ILLNESS:

Location: (where ?): Both sides / Left / Right _____

Duration: (how long?) _____

Severity: □mild, □moderate, □mod-severe, □severe, □fluctuates, □other: _____

Timing: □chronic (constant / most of the time), □acute, □sudden onset, □recurrent, □episodic, □comes and goes.

Context: (what brings it? What makes it worse?) _____

Treatment: Have you been evaluated or treated for this before? Yes / No _____

Have you seen a prior ENT doctor for this before? Yes / No _____

OTHER EAR, NOSE, THROAT ISSUES:

Ear/Hearing: _____

Nose/Sinus:_____

Throat:_____

ENT SURGERY: ❑**I never had any ENT surgery or procedures.** Tonsillectomy, Adenoid, Septoplasty, Turbinate surgery, Ear tubes, Sinus surgery, Broken nose repair, Polyp removal, Rhinoplasty, Thyroid surgery, Salivary gland removal, Ear surgery, Vocal cord growth removal, Facial fracture repair, Snoring surgery, Apnea surgery, Throat cancer removal, Tongue cancer removal, Eyelid surgery.
OTHER ENT surgery: _____

ALLERGIES TO MEDICATIONS ❑**NO allergies to meds**

Allergic to: (Circle all that apply) Penicillin , Sulfa, Erythromycin, Levaquin, Cipro, Neomycin, Iodine, Aspirin Dye/Contrast, Other ear drops, Tape, Adhesive, Latex, Ibuprofen, other NSAIDs, Reaction to general anesthesia.
OTHER:_____

MEDICATIONS & SUPPLEMENTS ❑**I do not take ANY medications or supplements.**

_____

_____

_____

PFSH (*PAST MEDICAL, FAMILY, & SOCIAL HISTORY)*

Please fill out the following questions. ***This is required by your insurer and the government for your coverage****. In each area, if you never had any problems in the category, then please check "No Problems." If you ever had any of the problems for the listed category,* ***PLEASE CHECK/CIRCLE ALL THAT APPLY****, or explain any that are not listed. If you have any questions about this, please ask one our nurses, staff, or your doctor*.

PAST MEDICAL HISTORY ❑**I never had any medical problems.**

High blood pressure/HTN, Heart problems, A-Fib, Blockage of heart vessels, Coronary artery disease, Heart attack, Heart valve problems, Low ejection fraction, Diabetes, Thyroid problems, Kidney problems, Kidney failure, Dialysis, Hepatitis, Liver disease, Asthma, COPD, Emphysema, Pneumonia, Bronchitis, Reflux, GERD, Blood clots, Stroke, Osteoporosis, Osteopenia, Autoimmune disease, Arthritis, Spine problems, Accidents, Falls, Cancer,
OTHER:_____

SURGERY & PROCEDURES ❑**I never had surgery or any procedures.** *V2.15.18*

Heart surgery, Stents, CABG, Vascular surgery (to open blood vessels), Gall bladder, Appendectomy, Cataracts, Weight loss surgery, Reflux surgery, Upper endoscopy, Colonoscopy, Stricture dilation ("stretched out") , Joint replacement, Fracture repair, Radiation therapy, Chemotherapy.
OTHER:_____

HOSPITALIZATIONS ❑**I was NEVER hospitalized.**

Please list: _____

_____

SOCIAL HISTORY (Circle what applies best).

Tobacco Never smoker, Former smoker (when quit?_____), Current every day smoker, Heavy Smoker, Current some day smoker, Light smoker**. #Packs/day**:_____ x #**Years smoked** _____

Alcohol Never drank, Former drinker (when quit?_____), Current every day drinker, Heavy drinker, Social alcohol, Light alcohol use. **#Drinks/week:**_____

Other Drugs: _____

FAMILY HISTORY

Do any "blood" relatives have these problems? Circle all that apply: Sinus problems, Allergies, Hearing Loss, Snoring, Sleep apnea, Reflux , Heart problems, Cancer, Asthma, Stroke, Bad reaction to general anesthesia,
OTHER_____

Circle and match to the family members who have the above problems.

Father, Mother, Brother, Sister, Grandfather, Grandmother, Son, Daughter, Other _____

REVIEW OF SYSTEMS

*Please fill out the following review of systems. This is **required by your insurer, and the government for your coverage**. In each area, if you are not having any difficulties, please check "No Problems." If you have had any of the symptoms listed, PLEASE CIRCLE ALL THAT APPLY.*

- **Const. (Health in General)** ❑**No Problems** Fever, chills, fatigue, lack of energy, weight gain, loss of appetite, night sweats. Other:_____
- **Ears, Nose, Mouth & Throat** ❑**No Problems** Ear problems, sinus problems, nasal problems, congestion difficulty with hearing, runny nose, post-nasal drip, ringing in ears, mouth sores, throat problems, nosebleeds, sore throat, facial pain, swollen glands, neck lump, ear wax clogging, ear pain.
  Other:_____
- **C-V (Heart & Blood Vessels)** ❑**No Problems** Chest pain, irregular heartbeat, racing heart, palpitations.
- **Resp. (Lungs & Breathing)** ❑**No Problems** Shortness of breath, cough, wheezing, phlegm, sleep apnea, snoring, poor quality sleep, prior tuberculosis, oxygen at home, abnormal chest x-ray. Other:_____
- **GI (Stomach & Intestines)** ❑**No Problems** Heartburn, difficulty swallowing, indigestion, nausea _____
- **GU (Kidney & Bladder)** ❑**No Problems** Kidney failure, kidney transplant, dialysis, prostate problems.
- **MS (Muscles, Bones, Joints)** ❑**No Problems** Neck pain, jaw joint pain, back pain, arthritis, *Use of:* cane, walker, wheelchair, need assistance when walking. Other:_____
- **Integ. (Skin, Subcutaneous)** ❑ **No Problems** Skin lesion, skin cancer, neck lump, cysts, scarring.
- **Neurologic (Brain & Nerves)** ❑**No Problems** Headaches, dizziness, lightheadedness, imbalance, loss of memory, problems walking, balance problems, falls, Other:_____
- **Psychiatric (Mood & Thinking)** ❑**No Problems** Anxiety, insomnia, irritability, depression, mood swings.
- **Endocrinologic (Glands)** ❑**No Problems** Thyroid lump, intolerance to heat or cold, high sugars.
- **Hematologic (Blood/Lymph)** ❑**No Problems** Easy bleeding, easy bruising, on blood thinners, anemia.
- **Allergic/Immunologic** ❑**No Problems** Seasonal allergies, frequent infections, low immunity, HIV.
- **Other Problems, Symptoms, Signs:** _____

Patient Signature: _____ ***Date:*** _____