MANCHESTER ENT
ear nose and throat

PATIENT NAME____

Reason for visit____

EAR			NOSE/SINUS			THROAT		
Hearing loss	Y	N	Discharge	Y	N	Extensive clearing	Y	N
Dizziness	Y	N	Facial pain	Y	N	Heartburn	Y	N
Discharge	Y	N	Injury	Y	N	Hoarseness	Y	N
Pain	Y	N	Loss of smell	Y	N	**Snoring**	Y	N
Itching	Y	N	Congestion	Y	N	Infection	Y	N
Plugged Sensation	Y	N	Itching	Y	N	Pain	Y	N
Noise/Ringing	Y	N	Bleeding	Y	N	Trouble swallowing	Y	N
			Nose Pain	Y	N			
			Postnasal drip	Y	N			
			Headache	Y	N			
			Infection	Y	N			

Have you ever been treated for or have any of the following medical conditions?

AIDS	Yes	No	Headaches	Yes	No
Anxiety	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No
Breathing problems	Yes	No	Herpes	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No
Depression	Yes	No	HIV	Yes	No
Depression w/anxiety	Yes	No	MRSA	Yes	No
Diabetes type I	Yes	No	Seasonal allergies	Yes	No
Diabetes type II	Yes	No	Other____________________		

Do you have any allergies to medications? Y N If yes, please list:______________________

Have your **parents/siblings/children** had allergies, sinus issues, hearing loss, cancer, heart disease?

Family Member Medical Issue

_______________ ______________________________

_______________ ______________________________

Do you drink alcohol? Yes No Do you smoke? Yes No

If no, did you ever smoke and when did you quit?______________________________

Please list all medications/vitamins including OTC with dosage that you are taking:____

____

Have you ever had ear, nose or throat surgery? Yes No

If yes, please explain____________________________________