Main Line HealthCare
Physician Network

ENT ASSOCIATES
PATIENT MEDICAL INFORMATION SHEET

PATIENT NAME _____ DATE _____

DATE OF BIRTH _____

REFERRING PHYSICIAN _____ PRIMARY PHYSICIAN _____

REASON FOR TODAYS VISIT _____

REVIEW OF SYSTEMS: Please check or write in any/all symptoms you are experiencing.

OVERALL
- ☐ I feel well
- ☐ I feel ill
- ☐ Other
- ☐ None

THROAT
- ☐ Sore throat
- ☐ Mouth pain
- ☐ Tongue pain
- ☐ Trouble swallowing
- ☐ Hoarseness/Voice change
- ☐ Lump in throat
- ☐ None

GI
- ☐ Reflux
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ None

NEURO
- ☐ Memory loss
- ☐ Dizziness
- ☐ Vertigo
- ☐ Headaches
- ☐ Vision changes
- ☐ Tremors
- ☐ Shooting pains
- ☐ Seizures
- ☐ Other
- ☐ None

EAR
- ☐ Ear pain/Ache
- ☐ Ear fullness
- ☐ Normal hearing
- ☐ Diminished hearing
- ☐ Overly sensitive
- ☐ Ringing in ears
- ☐ None

HEART
- ☐ Chest pains/Angina
- ☐ Palpitations
- ☐ Other
- ☐ None

LUNGS
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other
- ☐ None

URINARY TRACT
- ☐ Frequency
- ☐ Pain
- ☐ Blood in urine
- ☐ None

NOSE
- ☐ Congestion (stuffy)
- ☐ Drippy
- ☐ Postnasal drip
- ☐ Sinus pressure
- ☐ Headaches
- ☐ Decreased sense of smell
- ☐ Nosebleeds
- ☐ None

SKIN
- ☐ Rashes
- ☐ Drying
- ☐ Lesions/Spots
- ☐ Insect bites
- ☐ None

PSYCH
- ☐ Depression
- ☐ Anxiety
- ☐ Mood swings
- ☐ Other
- ☐ None

MUSCULOSKELETAL
- ☐ Muscle pain/Stiffness
- ☐ Joint pain/Stiffness
- ☐ Neck pain/Stiffness
- ☐ Upper extremity weakness
- ☐ Lower extremity weakness

ALLERGIES TO:

Medicines: _____

_____

Foods: _____

_____

Environment: _____

_____

Medical History: check all conditions you might have

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Malignancies (cancer)
- ☐ Diabetes
- ☐ Peptic ulcer disease
- ☐ AIDS/HIV
- ☐ Chronic ear problems
- ☐ Radiation/ Chemotherapy
- ☐ Seizures or neurologic problems
- ☐ Allergies/Asthma
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Other _____

PHYSICIAN SIGNATURE _____

SURGERIES: List all surgeries you have had

_____

_____

_____

MEDICINES: List all mediations, vitamins, herbs that you take (include amount and how often)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

Are you married? ☐ Yes ☐ Divorced ☐ Single ☐ Widowed

Do you have children?_____

Your occupation:_____

Your hobbies & avocations:_____

Do you drink alchohol: ☐ Yes ☐ No Amount_____

Do you smoke or chew tobacco: ☐ Yes ☐ No Amount_____ If you quit smoking, when_____

Have you been exposed to loud noises (military, industrial, music):_____

FAMILY HISTORY: Please list any significant diseases of your family members.

Mother_____ Siblings_____ Other_____

Father_____ Your children_____ _____

Please review this sheet each time you come to our office. List date, any information, your present problem or circle "No changes" & initial. Thank You

Date	Present Complaint	Changes to Medical Information		Initials
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____
_____	_____	_____	or "No Changes)	_____