Tustin ENT Sinus & Allergy Center

Tell us about the symptom(s) or reason(s) for your appointment:

Quality (pain, pressure, swelling, etc.) :_____
Location(s): _____
Severity (1-10 scale, 1=mild 10=severe): _____
How long have you had the issue? _____
Are the symptoms constant or when do they come and go?_____
What makes the symptom(s) better?_____ Worse? _____
What other symptoms are related to your primary issue? _____
What treatments have you attempted that have not helped? _____
Any other significant facts regarding this issue? _____
Estimated Height: _____ Estimated Weight (lbs): _____

Review of body systems: Please check if you have RECENTLY had any of these symptoms:

- ❏ Fever
- ❏ Chills
- ❏ Night sweats
- ❏ Unexplained weight gain
- ❏ Weight loss
- ❏ Excessive thirst
- ❏ Abdominal pain
- ❏ Chest pain
- ❏ Ear itching
- ❏ Ear pain
- ❏ Ear fullness or pressure
- ❏ Hearing loss
- ❏ Ringing
- ❏ Dizziness
- ❏ Spinning
- ❏ Ear drainage
- ❏ Nasal obstruction
- ❏ Nasal congestion
- ❏ Sneezing
- ❏ Postnasal drip
- ❏ Nose bleeding
- ❏ Runny nose
- ❏ Sore throat
- ❏ Swallowing difficulty
- ❏ Voice problems
- ❏ Rash
- ❏ Itching
- ❏ ulcers/growths
- ❏ Excess scarring
- ❏ Bleeding problems
- ❏ Dryness
- ❏ Suspicious lesions
- ❏ Hives
- ❏ Allergies
- ❏ Weakness
- ❏ Headache
- ❏ Numbness or tingling
- ❏ Seizures
- ❏ Fainting
- ❏ Vertigo
- ❏ Loss of vision
- ❏ Vision change
- ❏ Neck mass/lump
- ❏ Thyroid problems
- ❏ Cough
- ❏ Shortness of breath
- ❏ Sensitive to bright light
- ❏ Sensitive to loud noise
- ❏ Heartburn

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Past Medical History: Were you ever diagnosed with the following problems?

- ❏ High blood pressure
- ❏ Seizures
- ❏ Anxiety
- ❏ Depression
- ❏ Glaucoma
- ❏ Head injury
- ❏ Diabetes
- ❏ Arthritis
- ❏ High Cholesterol
- ❏ Kidney disease
- ❏ Heart disease
- ❏ Heart attack
- ❏ Thyroid problems
- ❏ GERD
- ❏ Allergies
- ❏ Asthma
- ❏ Prostates problems
- ❏ Stroke
- ❏ COPD
- ❏ Back or spine problems
- ❏ Hepatitis or liver problems
- ❏ Anemia
- ❏ Sleep apnea
- ❏ Migraines
- ❏ Autoimmune disease
- ❏ Cancer
- ❏ AIDS/HIV
- ❏ others: _____

Past Surgical History:
What surgeries have you previously undergone and when were they performed?

_____

_____

Immunizations: Last Flu vaccine _____ Pneumonia vaccine _____

Social History:
Have you ever smoked? _____ How much? _____ How many years?_____
When did you quit? _____Alcohol intake? _____ Illicit drugs? _____
Occupation and/or hobbies: _____ Children: _____ Pets: _____

Family Medical History: (please circle)

Cancer_____	Early Hearing Loss	Diabetes
Thyroid problems	Sleep apnea	Allergies
High blood pressure	others: _____	

Medication Allergies: Please list any medication allergies and specific reaction when taken:

_____

_____

List below or give a copy of the medications that you CURRENTLY take:

_____

_____

_____

_____