

RIVER CITIES EAR, NOSE AND THROAT SPECIALISTS

J. Brett Chafin, M.D.  
Pediatric Otolaryngologist

OD

Today's Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for today's

Visit: \_\_\_\_\_

**1. Past Medical History**

- |                                       |                                     |  |
|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> RSV        | <input type="checkbox"/> Anxiety                         |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> ADHD       | <input type="checkbox"/> Excessive bleeding              |
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Depression | <input type="checkbox"/> Gastroesophageal reflux disease |
| <input type="checkbox"/> NICU         | <input type="checkbox"/> PICU       | <input type="checkbox"/> Prematurity                     |

**2. List all medications the patient is allergic**

to: \_\_\_\_\_

Immunization up to date?  No  Yes

**3. List all medications the patient is taking or supply a list:**

\_\_\_\_\_

**4. List all surgeries that the patient has had:**

\_\_\_\_\_

**5. Family Medical History**

- |   |                                   |                                   |                                      |
|---|-----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Hypertension disease | <input type="checkbox"/> Asthma   | <input type="checkbox"/> Stroke   | <input type="checkbox"/> Heart       |
| <input type="checkbox"/> Free bleeding        | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine | <input type="checkbox"/> Other _____ |

**6. Patient Social History**

- |                  |                                |  |                                   |  |
|------------------|--------------------------------|--|-----------------------------------|--|
| Use of alcohol.  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely              | <input type="checkbox"/> Moderate | &n bsp; <input type="checkbox"/> Daily |
| Smoking:         | <input type="checkbox"/> No    | <input type="checkbox"/> Yes packs/day _____ |                                   |  |
| Chewing tobacco: | <input type="checkbox"/> No    | <input type="checkbox"/> Yes                 |                                   |  |

Use of drugs:  Never  Yes Type/Frequency \_\_\_\_\_

Coffee/tea \_\_\_\_\_  No  Yes Number of cups per day \_\_\_\_\_

Colas: \_\_\_\_\_  No  Yes Number of cans per day \_\_\_\_\_

**PLEASE COMPLETE OTHER SIDE**

**7. Review of Symptoms:**

**Do you have or have you had any of the following:**

	<b>NO</b>	<b>YES</b>	<b>EXPLAIN</b>
<u>CONSTITUTIONAL SYMPTOMS:</u> (good health, weight change, fever, fatigue)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>EARS, NOSE, THROAT AND MOUTH:</u> sp; _____ (nosebleed, sinus or nasal trouble, tonsillitis earache, hearing loss, dizziness, hoarseness, swallowing difficulty)	<input type="checkbox"/>	<input type="checkbox"/>	&nb
<u>EYES:</u> _____ (Eye disease or injury, blurred or double vision =0 A Wears glasses/contact lenses)	<input type="checkbox"/>	<input type="checkbox"/>	
<u>CARDIOVASCULAR:</u> _____ (heart murmur)	<input type="checkbox"/>	<input type="checkbox"/>	
<u>LUNGS:</u> _____ (chronic cough, asthma, shortness of breath)	&nbsp;[ ]	[ ]	
<u>GASTROINTESTINAL</u> _____ (hiatal hernia, blood stool, jaundice, nausea/vomiting, heartburn, reflux)	<input type="checkbox"/>	<input type="checkbox"/>	
<u>GENITOURINARY:</u> _____ (trouble urinating, kidney stones, bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	
<u>NEUROLOGICAL</u> _____ (headache, double vision, stroke)	&nbsp;[ ]	[ ]	
<u>HEMATOLOGY &amp; OTHERS:</u> _____ (anemia, allergy, bleeding tendency)	<input type="checkbox"/>	<input type="checkbox"/>	
<u>ENDOCRINOLOGY:</u> _____ (diabetes, hormonal problems, thyroid problems)		[ ] [ ]	
<u>ALLERGIC/IMMUNOLOGIC:</u> _____ (inhalant allergies, food allergies, allergy shots)	<input type="checkbox"/>	<input type="checkbox"/>	

MUSCULOSKELETAL:

[ ] [ ]

\_\_\_\_\_  
(joint pain, joint stiffness or swelling,  
muscle pain or cramps)

The above information is accurate to the best of my knowledge.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

I have reviewed the above information with the patient.

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**