KUNKES
EAR, NOSE, & THROAT PC

Welcome to Kunkes Ear, Nose, & Throat PC.

Please take a moment to help us by completing the information on the following pages. This data will assist us in providing you or your child with the best possible care. If you have any questions, a member of staff will be more than happy to assist you.

Name: _____ **Age:** _____ **Date of Birth:** _____
First MI Last MM / DD / YYYY

Who sent you to us today? _____

This person is :
- ☐ Primary physician
- ☐ Other physician
- ☐ Non-physician health care provider
- ☐ Friend / other

Gender: ☐ Male ☐ Female

Primary physician (name and phone number):

_____

_____

Please name the major problem or symptom that brings you to us today:

_____

_____

Please describe the history of your present illness in detail:

_____

_____

_____

_____

_____

_____

Rate the severity of **today's** symptoms on a 1 - 10 scale (10 = worst): _____

How long have your symptoms been present? _____

What makes your symptoms worse or better? _____

What other providers have you seen for this illness? _____

What diagnostic tests have been performed so far? _____

_____

_____

What treatments have been tried so far (include operations done for this illness)?

_____

_____

Please check yes for those symptoms below which apply to **you**, or no for those symptoms that do not apply:

	YES	NO		YES	NO		YES	NO
Severe headache	☐	☐	Nasal obstruction	☐	☐	Difficulty swallowing	☐	☐
Failing vision	☐	☐	Nosebleed	☐	☐	Can't clear throat	☐	☐
Eye pain	☐	☐	Loss of smell / taste	☐	☐	Cough	☐	☐
Double vision	☐	☐	Hearing loss	☐	☐	Hoarseness	☐	☐
Nasal congestion	☐	☐	Ringing in ears	☐	☐	Heartburn	☐	☐
Facial pain	☐	☐	Ear pain	☐	☐	Neck mass / swollen glands	☐	☐
Nasal discharge	☐	☐	Ear drainage	☐	☐	Snoring	☐	☐
Post-nasal drip	☐	☐	Dizzy / off balance	☐	☐	Stop breathing during sleep	☐	☐
Frequent sneezing	☐	☐	Ear fullness / pressure	☐	☐	Sleepy in the daytime	☐	☐

Reviewed by: _____

Review of Systems

Please check yes for those symptoms below which apply to **you**, and no for those symptoms that do not apply:

	YES	NO
Fever / Chills	☐	☐
Weight loss	☐	☐
Night sweats	☐	☐
Light bothers eyes	☐	☐
Irritated eyes	☐	☐
Eyes crust / drain	☐	☐
Chest pain	☐	☐
Irregular heartbeat	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Cough up blood	☐	☐
Abdominal pain	☐	☐
Nausea / Vomiting	☐	☐
Yellow jaundice	☐	☐
Bloody / black stool	☐	☐
Diarrhea	☐	☐
Painful Urination	☐	☐
Weak urine stream	☐	☐
Blood in urine	☐	☐
Painful / swollen joints	☐	☐
Back pain	☐	☐
Rash	☐	☐
Hair / Nail problems	☐	☐
Flaking / peeling skin	☐	☐
Itchy skin	☐	☐
Weakness	☐	☐
Shaking / tremor	☐	☐
Fainting	☐	☐
High stress	☐	☐
Depression	☐	☐
Mood swings	☐	☐
Cold intolerance	☐	☐
Heat intolerance	☐	☐
Frequent thirst	☐	☐
Anemia	☐	☐
Bruise easily	☐	☐
Prolonged bleeding	☐	☐
HIV Risk Factors	☐	☐

Past Medical History

Please check yes for those illnesses you **have** or **have had in the past.** Check no for those illnesses you **have never had:**

	YES	NO
Glaucoma	☐	☐
Cataract	☐	☐
Macular degeneration	☐	☐
High blood pressure	☐	☐
Past heart attack	☐	☐
Past stroke	☐	☐
Blocked arteries	☐	☐
Heart failure	☐	☐
Mitral valve prolapse	☐	☐
Past bypass surgery	☐	☐
Have pacemaker	☐	☐
Past angioplasty	☐	☐
Obstructive sleep apnea	☐	☐
Asthma	☐	☐
COPD / Emphysema	☐	☐
Tuberculosis	☐	☐
Pneumonia	☐	☐
Use oxygen at home	☐	☐
Reflux	☐	☐
Hiatal hernia	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Fibromyalgia	☐	☐
Gout	☐	☐
Arthritis	☐	☐
Seizure disorder	☐	☐
Parkinson's disease	☐	☐
Spinal injury	☐	☐
Head injury	☐	☐
Meningitis	☐	☐
Mental health problems	☐	☐
HIV positive	☐	☐
Low thyroid	☐	☐
Overactive thyroid	☐	☐
Thyroid nodule	☐	☐
Thyroid cancer	☐	☐
Diabetes - diet control	☐	☐
Diabetes - oral meds	☐	☐
Diabetes - insulin	☐	☐
Food allergy	☐	☐
Contact allergy	☐	☐
Latex allergy	☐	☐
Adhesive tape allergy	☐	☐
Inhalant allergy	☐	☐
Previous skin tests	☐	☐
Bleeding disorder	☐	☐
Use aspirin	☐	☐
Use Coumadin	☐	☐
Use Plavix	☐	☐
Use non steroidal (such as ibuprofen, Aleve)	☐	☐
Use other blood thinner	☐	☐

Please list all food, contact and inhalant allergies.
Do **not** include drug allergies. Include any prior skin test results:

_____

_____

If you answered yes to any above, please explain. Please tell us anything else we should know about your medical history:

_____

_____

_____

Do you have any history of cancer? _____ If yes, please list site(s) and treatment:

_____

_____

Reviewed by: _____

Surgical History

Please list all prior surgical procedures

Operation	Date

Operation	Date

Medications you take

Include vitamins, supplements, herbals

Name	Dose

Name	Dose

Your Drug Allergies

List all allergies and bad reactions to medications

Name	Reaction
Latex allergy?	yes / no
Adhesive tape allergy?	

Family History

Please check yes for those illnesses that are present **in your immediate blood relatives (parents, children or siblings):**

	YES	NO		YES	NO		YES	NO
Heart attack / disease	☐	☐	High blood pressure	☐	☐	Hearing loss	☐	☐
Blocked arteries	☐	☐	Diabetes	☐	☐	Sickle cell / trait	☐	☐
Past stroke	☐	☐	Thyroid problems	☐	☐	Bleeding problem	☐	☐
Allergies	☐	☐	Cancer	☐	☐	Asthma	☐	☐

Other family illness: ☐ ☐ if yes, please list:

_____

_____

Social History:

What type of work / school do you do? _____

Who lives with you at home? _____

You smoke _____ packs of cigarettes a day - ***OR*** - you smoked _____ packs per day, then quit _____ years ago

You consume _____ alcoholic beverages **per day / week / month (circle)**

You consume _____ caffeine beverages per day (coffee, tea, ice tea, coke, mountain dew, etc.)

You consume _____ glasses of water per day

Is there any chance you may be pregnant? _____

Reviewed by: _____