Cleveland Head and Neck Clinic

Today's Date_____

Patient's Name_____ **Date of Birth**_____

Name of favorite pharmacy, address, and phone number_____

Chief complaint (Why you are here today?) _____
Location/When did it start? _____
Quality of the Problem (Sharp or Dull pain?)_____
Severity (Mild, Moderate, or Severe)_____
Timing (During exercise, at night, gets worse in the spring, etc.)_____
Context (Worsening, Recurrent)_____
What makes it better (Heat, Cold, Rest, Tylenol, etc.)_____
Associated Symptoms_____

CIRCLE ALL THAT APPLY:

General:	Fevers	Chills	Weight Gain	Weight Loss	Fatigue		
Ears:	Hearing Loss	Ear noise/ Tinnitus	Pain	Fullness/ Pressure	Wax	Ear Drainage	
Nose:	Stuffy	Runny	Seasonal Allergies	Sneezing	Snoring	Facial Pain	Bleeding
Throat:	Mouth sores	Sore tongue	Lump in throat	Hoarseness	Difficulty Swallowing		
Skin:	Rash	Itching	Easy bruising	Bleeding	Edema		
Allergic/ Immunologic:	Hives	Persistent Infections	HIV Exposure	Blood Transfusions			
Neurologic:	Headache	Head Trauma	Anxiety/ Depression	Tremors	Weakness	Numbness/ Tingling	Seizures
Vestibular:	dizziness						
Eyes:	Blurring/double vision	Eye Pain	Itchy/ watery eyes	Vision Loss	Light sensitivity		
Neck:	Lump/Mass	Thyroid problem	Heat or cold intolerance	Rapid heart rate			
Respiratory:	Cough	Shortness of Breath	Phlegm	Wheezing	Chest Pain		
Gastrointestinal:	Heartburn	Gas	Abdominal Pain	Constipation	Diarrhea	Dark/bloody stool	
Musculoskeletal:	Joint pain	Jaw pain	Neck pain	Back pain	Muscle pain		
Genitourinary:	Frequent urination	Painful urination	Urinary/vaginal bleeding				

PAST HISTORY: Check all that apply:

__Hypertension/High Blood Pressure
__Cancer
__Diabetes Mellitus
__Temporomandibular Joint Disorder (TMJ)
__Heart Attack/Coronary Artery Disease
__Arthritis/Rheumatoid
__High Cholesterol
__Lupus
__Arrhythmia
__Fibromyalgia
__COPD/Emphysema
__Thyroid Disorder (nodules, hypo, hyper)
__Asthma
__Parathyroid Disease
__Tuberculosis
__Multiple Sclerosis
__GERD (Esophageal Reflux)
__Parkinson's Disease
__Peptic Ulcers
__Stroke
__Hepatitis/Liver Disease
__Hearing Loss
__Kidney Disease/Chronic Renal Failure
__Glaucoma
__Kidney Stones
__Anxiety/Depression
__Gout
__Bleeding Disorder
__Allergic Rhinitis
__Deep Vein Thrombosis
__HIV/AIDS
__Obstructive Sleep Apnea

Please list any other medical conditions: _____

Operations:

1. _____Date: _____
2. _____Date: _____
3. _____Date: _____
4. _____Date: _____
5. _____Date: _____

Please write which family members have had the following (leave blank if none):

Hypertension_____ Thyroid Disease_____

Heart Disease_____ Hearing Loss/Ear Disease_____

Diabetes_____ Bleeding Problems_____

Cancer_____ Anesthesia Problems_____

Social History

Smoking No Yes How Much? _____

Chewing Tobacco No Yes How Much?_____

Alcohol Use No Yes How Much?_____

Occupation: _____

Allergic to Medications? No Yes Please list_____
_____

Allergic to Latex? No Yes_____

Medications:

Name	Dose	Taken for?

If female, are you pregnant? No Yes

For office use only:

Height:_____ Weight:_____ Temp:_____ B/P:_____ Pulse:_____