Allergy, Ear, Nose & Throat
Associates of Texas
Tariq M. Yunus, MD

PATIENT NAME

DATE

PATIENT HISTORY AND REVIEW OF SYSTEMS

PAST MEDICAL HISTORY Check (✓) conditions you have or have had in the past.

☐ AIDS/HIV	☐ Bleeding Disorders	☐ Epilepsy	☐ Migraine Headaches	☐ STD
☐ Alcoholism	☐ Cancer	☐ Heart Disease	☐ Miscarriage	☐ Stroke
☐ Anemia	☐ Cataracts/Glaucoma	☐ Hepatitis	☐ Mononucleosis	☐ Suicide Attempt
☐ Anorexia/Bulimia	☐ Chemical Dependency	☐ Hernia	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Arthritis	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tuberculosis
☐ Asthma/Bronchitis	☐ Emphysema	☐ Kidney/Liver Disease	☐ Psychiatric Care	☐ Ulcers

SOCIAL HISTORY Check (✓) and describe all that apply.

☐ **Alcohol:** Type_____ Amount _____Frequency_____
☐ **Antacids:** Type _____ Used For:_____ Frequency_____
☐ **Tobacco Use:** Type_____ Amount Daily_____ How long _____
☐ **Caffeine:** Type_____ Amount Daily _____
☐ **Exercise:** Regularly ☐Yes ☐No Activity_____ Frequency_____
☐ **Sleep:** ☐ Difficulty falling asleep ☐ Frequent awakenings ☐ Early morning awakening ☐ Snoring ☐ Daytime drowsiness

FAMILY HISTORY Please explain Whom in your family has the following.

Diabetes: **Cancer:** **Thyroid Disease:**

PAST SURGERIES AND HOSPITALIZATIONS (with year of occurrence).

_____

CURRENT MEDICATIONS

_____
_____
_____

ALLERGIES TO MEDICATIONS

REASON FOR VISIT

REVIEW OF SYSTEMS Check (✓) symptoms you currently have or recently had.

EYES
☒ Eye disease or injury
☒ Vision changes
☒ Wear glasses/contact lenses

EAR, NOSE, THROAT
☒ Bleeding gums
☒ Tongue Problems
☒ Difficulty swallowing
☒ Earache
☒ Ear discharge
☒ Hay fever or allergies
☒ Hearing loss
☒ Hoarseness
☒ Lump in the neck
☒ Mouth sore
☒ Nasal discharge
☒ Nasal stuffiness
☒ Neck pain
☒ Nose bleeding
☒ Cough
☒ Ringing in ears
☒ Sinus problems
☒ Snoring
☒ Sore throat

GENERAL
☒ Chills
☒ Fainting or Dizziness
☒ Fatigue
☒ Fever
☒ Headache
☒ Loss of appetite
☒ Loss of weight
☒ Sweats

CARDIOVASCULAR
☒ Chest pain
☒ High or low blood pressure
☒ Irregular or rapid heart beat
☒ Poor circulation
☒ Varicose veins

RESPIRATORY
☒ Spitting up blood
☒ Shortness of breath
☒ Asthma or Wheezing

GENITO-URINARY
☒ Blood in urine
☒ Frequent or painful urination
☒ Lack of bladder control

GASTROINTESTINAL
☒ Black or tarry stools
☒ Change in bowel movements
☒ Constipation
☒ Diarrhea
☒ Excessive hunger or thirst
☒ Indigestion or heartburn
☒ Loss of appetite
☒ Nausea or vomiting
☒ Stomach pain
☒ Vomiting blood

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
☒ Arms or Legs
☒ Back or Body
☒ Joints

NEUROLOGICAL
☒ Tremors
☒ Paralysis
☒ Stroke
☒ Head injury

ENDOCRINE
☒ Glandular or hormone problem
☒ Thyroid disease
☒ Diabetes (insulin or non insulin)
☒ Change in hat or glove size

HEMATOLOGIC/LYMPHATIC
☒ Slow to heal after cuts
☒ Bleeding or bruising tendency
☒ Anemia
☒ Phlebitis
☒ Past transfusion

SKIN
☒ Change in hair or nails
☒ Hives
☒ Itching
☒ Rash
☒ Scars
☒ Sore that won't heal

Date of last physical exam

_____

Are you pregnant? ☒Yes ☒No