# WESTCHESTER E.N.T.
## PATIENT SELF ASSESSMENT FOR INITIAL VISIT

We ask that all of our patients fill out this form at the time of their first visit to our office. Please do your best to answer all the questions. If you do not understand a question, your doctor or nurse can explain it. These questions are meant to help us take care of you. Everything is CONFIDENTIAL and will become part of your medical record.

What is your name?_________________________________________________ Today's Date?_________________
Your date of birth? _______________________
What brings you in today?_________________________________________________________________________

If you have a regular doctor, please list his or her name, address and phone number:_______________________________
_____________________________________________________________________________________________
How did you hear about our practice?__________________________________________________________________________________

**Current Problems:**
Do you have any illnesses or medical conditions now? ☐ YES ☐ NO
If yes, please list them:_____________________________________________________________________________
_____________________________________________________________________________________________

**<u>Past Medical History</u>:** Have you ever had any of the following? (please check all that apply)

☐ Cancer ☐ High blood pressure ☐ Stroke ☐ Diabetes ☐ Asthma/Allergy ☐ Depression
☐ Arthritis ☐ Acid Reflux ☐ Heart disease ☐ Serious Injury ☐ Hepatitis ☐ Substance Abuse

Have you ever been hospitalized? ☐ YES ☐ NO If yes, list when and why:
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Have you ever had an operation? ☐ YES ☐ NO If yes, please list type of surgery and year (include tonsils)
_____________________________________________________________________________________________
_____________________________________________________________________________________________

**MEDICATIONS:**
**List all your medications and doses:**

| | Name | Dose | Route | How often do you take it? |
|---|---|---|---|---|
| EXAMPLE: | Tylenol | 650 mg | oral | Four times daily |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

List any vitamins, herbs, supplements, or over the counter medications you take, even if you use them only rarely:

**Allergies:**
Do you have any allergies to medications? ☐ YES ☐ NO If yes, what?______________________________________
Do you have any allergies to food? ☐ YES ☐ NO If yes, what? ______________________________________

**Family History:**
Do any of your family members have or did they have in the past?

☐ Diabetes ☐ Depression ☐ Stroke ☐ High Blood Pressure ☐ Alcoholism ☐ Cancer
☐ Heart disease ☐ Heart attack ☐ Asthma ☐ Tuberculosis ☐ Thyroid disease ☐ Glaucoma

**Details regarding the health of your family:**

| | Age or Age at Death | Medical problems or cause of death |
|---|---|---|
| Father | _____ | ____________________________________________ |
| Mother | _____ | ____________________________________________ |
| Siblings | _____ | ____________________________________________ |
| | _____ | ____________________________________________ |
| Children | _____ | ____________________________________________ |
| | _____ | ____________________________________________ |

Do you have a preferred pharmacy? If yes, please write the name, address and phone number:
_____________________________________________________________________________________________

(Please turn over and complete the other side)

Name:__________________________________________ Date of Birth:_______________________

**Social History:** (please check all that apply)

☐You smoke cigarettes ☐You smoked cigarettes in the past ☐ Anyone you live with or work closely with smokes

☐You drink alcohol currently ☐ You drank alcohol in the past

☐You use any drugs (for example: marijuana, cocaine, heroin) ☐ You used drugs in the past

☐You have any religious or cultural beliefs that your doctor should know about before beginning medical treatment

What is your occupation? _________________________ What is the last grade in school you completed? ________________

**REVIEW OF SYSTEMS:** Do you currently have any of the following? (please check all that apply)

**Constitutional:**
- ☐ Recent weight change of more than 10 pounds
- ☐ Worry/ preoccupation with weight
- ☐ Decreased appetite
- ☐ Frequent fevers/ night sweats
- ☐ Fatigue/ weakness
- ☐ Difficulties sleeping
- ☐ Special diet
- ☐ Excessive daytime sleepiness

**Eyes:**
- ☐ Wear glasses/ contact lenses
- ☐ Blurred or double vision
- ☐ Burning/ itching/ watery eyes
- ☐ Pain/ redness

**Ears, Nose, and Throat:**
- ☐ Difficulty hearing
- ☐ Ringing in the ears/Tinnitus
- ☐ Pain in the ears
- ☐ Drainage from the ears
- ☐ Dizziness
- ☐ Off balance or unable to tolerate motion
- ☐ Stuffy nose
- ☐ Nose bleeds
- ☐ Diminished sense of smell or taste
- ☐ A lot of mucus when you blow your nose
- ☐ Nose feels too dry or burning
- ☐ Runny nose
- ☐ Post-nasal drip
- ☐ Too much phlegm in your throat
- ☐ Sinus headaches
- ☐ Snoring
- ☐ Waking up choking or gasping for breath
- ☐ Mouth sores
- ☐ Hoarseness/changes in your voice
- ☐ Difficulty swallowing or choking on your food
- ☐ Painful swallowing
- ☐ Chronic/ frequent coughing
- ☐ Current sore throat
- ☐ History of chronic/ recurrent sore throats
- ☐ Feeling something is stuck in your throat/ frequent throat clearing
- ☐ Throat feels too dry or burning
- ☐ Dental problems
- ☐ Bad breath
- ☐ Tongue film
- ☐ Considering Botox injections/fillers

**Endocrine:**
- ☐ Goiter now or in past
- ☐ Bothered excessively by hot or cold weather
- ☐ Excessive sweating
- ☐ Thirsty most of the time
- ☐ High blood sugar

**Hematologic/ Lymphatic:**
- ☐ Bleeding/ bruising easily
- ☐ Lumps in neck, armpits, groin
- ☐ Low blood count in past

**Allergic/Immunologic:**
- ☐ Recurrent infections
- ☐ Allergies or hay fever
- ☐ Frequent sneezing

**Neurological:**
- ☐ Frequent headache
- ☐ Numbness, pain or tingling of arms or legs
- ☐ Muscle weakness
- ☐ Convulsions/ seizures
- ☐ Memory problems
- ☐ History of mini strokes

**Psychiatric:**
- ☐ Hospitalized for mental or nervous disorder
- ☐ Depressed or sad
- ☐ Nervous or anxious
- ☐ Excessive stress
- ☐ Sleep problems

**Musculoskeletal:**
- ☐ Painful or swollen joints
- ☐ Trouble with your back
- ☐ Difficult or painful walking
- ☐ Fell down within the last year
- ☐ Pain/stiffness in your neck

**Respiratory:**
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Dry cough
- ☐ Wet (productive) cough

**Gastrointestinal:**
- ☐ Black or bloody stools
- ☐ Hemorrhoids
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation or use of laxatives
- ☐ Change in bowel habits
- ☐ Abdominal pain/ heartburn

**Genitourinary:**
- ☐ Frequent urination
- ☐ Urinating frequently at night
- ☐ Burning or pain on urination
- ☐ Blood in urine
- ☐ Difficulty holding urine
- ☐ Sexual dysfunctions

**Skin:**
- ☐ Rashes or itching
- ☐ Change in skin color
- ☐ Moles on your face, neck or scalp
- ☐ Lumps under the skin of the face, neck or scalp

**Cardiovascular:**
- ☐ Palpitations/feeling like your heart is racing
- ☐ Chest pain/ tightness
- ☐ Fainting
- ☐ Swelling of feet/legs
- ☐ Irregular heart beat
- ☐ Heart murmur
- ☐ Unable to climb 2 flights of stairs

**Women:**
- ☐ Vaginal bleeding between periods or after intercourse
- ☐ Vaginal discharge or lesions
- ☐ Discharge or lump in breast

**Men:**
- ☐ Discharge or drip from penis
- ☐ Sore or lump near or on penis
- ☐ Lump on testicles