Main Line HealthCare
Physician Network

ENT ASSOCIATES
PATIENT MEDICAL INFORMATION SHEET

PATIENT NAME____________________________ DATE ____________

DATE OF BIRTH ________________

REFERRING PHYSICIAN ________________ PRIMARY PHYSICIAN ________________

REASON FOR TODAYS VISIT ____________________________

REVIEW OF SYSTEMS: Please check or write in any/all symptoms you are experiencing.

OVERALL
- ☐ I feel well
- ☐ I feel ill
- ☐ Other
- ☐ None

THROAT
- ☐ Sore throat
- ☐ Mouth pain
- ☐ Tongue pain
- ☐ Trouble swallowing
- ☐ Hoarseness/Voice change
- ☐ Lump in throat
- ☐ None

GI
- ☐ Reflux
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ None

NEURO
- ☐ Memory loss
- ☐ Dizziness
- ☐ Vertigo
- ☐ Headaches
- ☐ Vision changes
- ☐ Tremors
- ☐ Shooting pains
- ☐ Seizures
- ☐ Other
- ☐ None

EAR
- ☐ Ear pain/Ache
- ☐ Ear fullness
- ☐ Normal hearing
- ☐ Diminished hearing
- ☐ Overly sensitive
- ☐ Ringing in ears
- ☐ None

HEART
- ☐ Chest pains/Angina
- ☐ Palpitations
- ☐ Other
- ☐ None

LUNGS
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other
- ☐ None

URINARY TRACT
- ☐ Frequency
- ☐ Pain
- ☐ Blood in urine
- ☐ None

NOSE
- ☐ Congestion (stuffy)
- ☐ Drippy
- ☐ Postnasal drip
- ☐ Sinus pressure
- ☐ Headaches
- ☐ Decreased sense of smell
- ☐ Nosebleeds
- ☐ None

SKIN
- ☐ Rashes
- ☐ Drying
- ☐ Lesions/Spots
- ☐ Insect bites
- ☐ None

PSYCH
- ☐ Depression
- ☐ Anxiety
- ☐ Mood swings
- ☐ Other
- ☐ None

MUSCULOSKELETAL
- ☐ Muscle pain/Stiffness
- ☐ Joint pain/Stiffness
- ☐ Neck pain/Stiffness
- ☐ Upper extremity weakness
- ☐ Lower extremity weakness

ALLERGIES TO:

Medicines:________________________

Foods:________________________

Environment:________________________

Medical History: check all conditions you might have
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Malignancies (cancer)
- ☐ Diabetes
- ☐ Peptic ulcer disease
- ☐ AIDS/HIV
- ☐ Chronic ear problems
- ☐ Radiation/ Chemotherapy
- ☐ Seizures or neurologic problems
- ☐ Allergies/Asthma
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Other________________

PHYSICIAN SIGNATURE________________________

SURGERIES: List all surgeries you have had

____

____

____

MEDICINES: List all mediations, vitamins, herbs that you take (include amount and how often)

______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______

SOCIAL HISTORY:

Are you married? ☐ Yes ☐ Divorced ☐ Single ☐ Widowed

Do you have children?______________________

Your occupation:______________________

Your hobbies & avocations:______________________

Do you drink alchohol: ☐ Yes ☐ No Amount______________________

Do you smoke or chew tobacco: ☐ Yes ☐ No Amount______________ If you quit smoking, when________

Have you been exposed to loud noises (military, industrial, music):______________________

FAMILY HISTORY: Please list any significant diseases of your family members.

Mother______________ Siblings______________ Other______________

Father______________ Your children______________ ______________

Please review this sheet each time you come to our office. List date, any information, your present problem or circle "No changes" & initial. Thank You

Date	Present Complaint	Changes to Medical Information		Initials
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______
______	______	______	or "No Changes)	______