The Toledo Clinic | ENT

Adult History and Physical

Patient Name ______________________ Sex ☐ M ☐ F DOB ____/____/______
First Last MI MM DD YYYY

Primary Care Physician ______________________ Age ______

Pharmacy ______________________ Pharmacy Phone # ______________________

Reason for Referral ______________________ Onset of Symptoms ______________________

TO BE COMPLETED BY PATIENT

Do you have a history of any of the following?

METABOLIC/CIRCULATORY

☐ Diabetes ☐ Bleeding Tendencies ☐ High Blood Pressure ☐ Thyroid Disorder
☐ Heart Disease/Attack ☐ Rheumatic Fever

RESPIRATORY

☐ Pneumonia ☐ Asthma ☐ Bronchitis ☐ Lung Problems

NEUROLOGIC

☐ Migraines ☐ Headaches ☐ Seizures/Convulsion

DIGESTIVE

☐ Acid Reflux/GERD ☐ Other ______________

IMMUNE

☐ HIV/AIDS/STD ☐ Seasonal Allergies ☐ Food Allergies ☐ Animal Allergies
☐ Eczema ☐ Arthritis ☐ Yeast/Fungal Infection ☐ Allergies to IV Contrast

CANCER

Type: ______________ ☐ Chemotherapy ☐ Radiation Therapy Location ______________

EAR, NOSE & THROAT

☐ Strep Throat ☐ Tonsillitis ☐ Sinus Problems ☐ Snoring
☐ Ear Infections ☐ Hearing Loss ☐ Tinnitus ☐ Dizziness

Please describe any other problems we need to be aware of: ______________________

Do you have allergies to any medications? Please list ______________________

5800 Park Center Ct., Suite C, Toledo, OH 43615
(419) 724-8368 • www.ToledoClinicENT.com • www.ToledoRhinoplasty.com

Exposure to Tobacco ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Packs per day ______ Years quit? ______ Do you drink? ☐ Yes ☐ No Drinks per day ______

Do you chew? ☐ Yes ☐ No

Do you use snuff? ☐ Yes ☐ No

Are your immunizations up to date? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Current Medications & Supplements ____

____

____

____

SURGICAL HISTORY

Type of Surgery	*Year of Surgery*	*Right/Left*

Have you had any complications to any surgeries? (please describe)

____

____

FAMILY HISTORY

Mother	☐ Alive	☐ Deceased		
Father	☐ Alive	☐ Deceased		
Asthma	☐ Father	☐ Mother	☐ Brother	☐ Sister
Bleeding Tendencies	☐ Father	☐ Mother	☐ Brother	☐ Sister
Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Diabetes	☐ Father	☐ Mother	☐ Brother	☐ Sister
Ear Infections	☐ Father	☐ Mother	☐ Brother	☐ Sister
Ear Surgeries	☐ Father	☐ Mother	☐ Brother	☐ Sister
Food Allergies	☐ Father	☐ Mother	☐ Brother	☐ Sister
Early Hearing Loss	☐ Father	☐ Mother	☐ Brother	☐ Sister
Heart Disease	☐ Father	☐ Mother	☐ Brother	☐ Sister
High Blood Pressure	☐ Father	☐ Mother	☐ Brother	☐ Sister
Seasonal Allergies/Hay Fever	☐ Father	☐ Mother	☐ Brother	☐ Sister
Stroke	☐ Father	☐ Mother	☐ Brother	☐ Sister