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PATIENT HISTORY: GENERAL MEDICAL BACKGROUND

NAME: _____

DATE: _____

PLEASE CHECK

ALL ANSWERS THAT APPLY

1. BRIEF SUMMARY OF ENT PROBLEMS, SOME OF WHICH MAY NOT BE RELATED TO YOUR PRESENT COMPLAINT:

- | | | |
|--|--|--|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Trouble swallowing |
| <input type="checkbox"/> Ear noises | <input type="checkbox"/> Severe snoring | <input type="checkbox"/> Trouble breathing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Lump in neck |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Lump in face or head |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Jaw joint problem | <input type="checkbox"/> Taste or smell disorder |
| <input type="checkbox"/> Facial paralysis | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Excess eye skin |
| <input type="checkbox"/> Nasal obstruction | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Excess facial skin |
| <input type="checkbox"/> Nasal deformity | <input type="checkbox"/> Eye problem | <input type="checkbox"/> Other, please list: |
| <input type="checkbox"/> Nose bleeds | | |

2. DO YOU HAVE OR HAVE YOU EVER HAD:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Psych. therapy |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Arthritis or skeletal problems | <input type="checkbox"/> Cold sores (fever blisters) |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Cancer of | <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Other tumor | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Lung or breathing problems | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Intravenous antibiotics or diuretics | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Other heart problems | <input type="checkbox"/> Frequent bad headaches | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Severe low blood pressure | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Other illnesses, please list: |

3. DO ANY BLOOD RELATIVES HAVE:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Bleeding or clotting disorder | <input type="checkbox"/> Other major medical problems such as those above. Please list: |

4. DESCRIBE SERIOUS ACCIDENTS UNLESS DIRECTLY RELATED TO YOUR DOCTOR'S VISIT
HERE.

- None
 Occurred with head injury, loss of consciousness or whiplash.
 Occurred without head injury, loss of consciousness or whiplash. Describe:

5. MEDICATION ALLERGIES:

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Keflex/Ceclor/Ceftin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> X-ray dyes | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Novocaine | <input type="checkbox"/> Adhesive tape |
| <input type="checkbox"/> Other, please list: | | |

6. OTHER ALLERGIES:

NAME AND ADDRESS OF ALLERGIST, IF YOU HAVE ALREADY BEEN EVALUATED:

7. LIST ALL CURRENT MEDICATIONS AND DOSES (INCLUDE BIRTH CONTROL PILLS AND VITAMINS).

8. LIST OPERATIONS:

- Tonsillectomy (age ___) Adenoidectomy (age _____)
 Appendectomy (age ___) Heart surgery (age _____)
 Other, please list:

9. SMOKING HISTORY:

- Never
 Quit. When? _____ Smoked about _____ per day for _____ years.
 Smoke. _____ packs per day. Have smoked for _____ years.

10. ALCOHOL:

- No (rarely) alcohol
How much of what per day?

11. CAFFEINE CONSUMPTION:

_____ cup(s) or glass(es) per day (coffee, tea, cola, chocolate, etc.)

12. LIST OTHER DRUGS YOU USE.

_____ Marijuana _____ Heroin
_____ Cocaine _____ Ecstasy
_____ Other

13. LIST TOXIC DRUGS OR CHEMICALS TO WHICH YOU HAVE BEEN EXPOSED:

___ Lead Streptomycin, Neomycin, Kanamycin
___ Mercury Other, please list:

14. HAVE YOU HAD X-RAY TREATMENTS TO YOUR HEAD OR NECK (INCLUDING TREATMENTS FOR ACNE OR EAR PROBLEMS AS A CHILD), TREATMENTS FOR CANCER, ETC?

___ Yes No

15. WHAT IS YOUR OCCUPATION?

WHAT OCCUPATION(S) DID YOU HOLD PREVIOUSLY? (INCLUDE INFORMATION ON EXPOSURE TO NOISE, TOXIC SUBSTANCES OR OTHER HEALTH HAZARDS).

16. LIST NAMES OF SPOUSE AND CHILDREN.

17. DESCRIBE SERIOUS HEALTH PROBLEMS OF YOUR SPOUSE OR CHILDREN.

None

18. FOR FEMALES:

_____ YES/NO Are you pregnant?
_____ YES/NO Are you post-menopausal?
_____ YES/NO Have you undergone hysterectomy?
_____ YES/NO Were your ovaries removed?
_____ YES/NO Are your menstrual periods regular?

19. ARE YOU CURRENTLY CONTEMPLATING OR INVOLVED IN LITIGATION (LEGAL ACTION) RELATED TO YOUR HEALTH?