SRMC
SOUTHSIDE REGIONAL
PHYSICIANS NETWORK
Southside Regional Ear, Nose & Throat Specialists

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Patient Name ______________________ Patient Date of Birth ____________

If you have any of these problems, please check:

Eyes
- ☐ Infections/Injuries
- ☐ Glaucoma
- ☐ Cataracts

Ear, Nose, Throat & Mouth
- ☐ Hearing Loss
- ☐ Ear Pain / Infections
- ☐ Ringing in Ears
- ☐ Balance Disturbance (e.g. Vertigo, Spinning)
- ☐ Nosebleeds
- ☐ Nasal Congestion
- ☐ Frequent Nasal Drainage Color ________________
- ☐ Inability to Smell
- ☐ Sinus Problems
- ☐ Frequent Sore Throat
- ☐ Mouth Sores

Cardiovascular
- ☐ Chest Pain or Angina
- ☐ High Blood Pressure
- ☐ Irregular Pulse
- ☐ Heart Murmur
- ☐ Swelling in Feet or Hands

Respiratory
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Lung Cancer
- ☐ Bloody Sputum

Genitourinary
- ☐ Urinary Tract Infections
- ☐ Painful Urinations
- ☐ Blood in Urine
- ☐ Difficulty starting or stopping stream
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Prostate Cancer (males)
- ☐ Endometriosis (females)
- ☐ Uterine / Cervical Cancer (females)

Musculoskeletal
- ☐ Arm or Leg Pain / Weakness
- ☐ Back pain
- ☐ Joint pain or swelling
- ☐ Arthritis

Neurological
- ☐ Seizures
- ☐ Problems with your memory
- ☐ Disorientation
- ☐ Difficulty with your speech
- ☐ Inability to Concentrate
- ☐ Double or blurred vision
- ☐ Face Weakness
- ☐ Lack of coordination in arms and/ or legs

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Increased Appetite
- ☐ Excessive Thirst or Urination
- ☐ Hormone Problems

Integumentary
- ☐ Skin Disease
- ☐ Skin Cancer

Gastrointestinal
- ☐ Indigestion or Pain with Eating
- ☐ Nausea
- ☐ Vomiting
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Abdominal Pain
- ☐ Change in your bowel habits
- ☐ Ulcers or Gastritis
- ☐ Colon Cancer

Allergic Immunologic
- ☐ Food Allergies
- ☐ Inhalant (nasal) Allergies
- ☐ Immunologic Disorders

Hematologic / Lymphatic
- ☐ Anemia
- ☐ Hemophilia
- ☐ Bleeding Tendencies
- ☐ Persistent Swollen Glands or Lymph Nodes
- ☐ Blood Transfusion
  If yes, when? ________________

Constitutional
- ☐ Fever
- ☐ Weight Loss
- ☐ Excessive Fatigue
- ☐ Night Sweats
- ☐ Headache

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Other Psychiatric Disorder / Treatment

____
____
____

PAST MEDICAL HISTORY

Please list any prior major illnesses or injuries:

____

____

____

Please list any Surgeries or Hospitalizations (and the year):

____

____

____

Have you had any problems with anesthesia? ☐ No ☐ Yes If yes, please describe: ____________________________

Have any family members had high fever from anesthesia? ☐ No ☐ Yes

Have you had any reaction from contact to latex? ☐ No ☐ Yes

Please list current medications (Please include vitamins, nutrients, herbs, 'natural medicines', etc.)

Medication Dose Frequency

____

____

____

Do you take aspirin containing products, Advil, Motrin or blood thinners? ☐ No ☐ Yes

Do you take Birth Control pills? ☐ No ☐ Yes

Is there any chance that you are currently pregnant? ☐ No ☐ Yes

Do you have a medication allergy? ☐ No ☐ Yes (If yes, please list below)

Medication Type of reaction

____

____

____

Marital Status: ☐ M ☐ S ☐ D ☐ W

Do you have children? ☐ No ☐ Yes Ages: ___________________________

Do you live alone? ☐ No ☐ Yes

Do you smoke cigarettes, cigars and/or chew tobacco? ☐ No ☐ Yes (__________ quantity/day for ____ years)

☐ I quit _____ years ago, but before that I smoked _______ quantity/ day for _____ years)

Do you drink alcohol? ☐ No, never, rarely. ☐ No, but I used to drink heavily.

☐ Yes. ☐ Daily ☐ 1 or more times weekly ☐ 1 or more times monthly

Are you at risk for blood borne illnesses (i.e. by blood transfusion, by IV drug use or by sexually transmitted disease)?

☐ No ☐ Yes, ____

Please list any serious illnesses in close family members or any 'hereditary diseases' that run in your family:

____

____

____

Signature of Reviewing Physician: ___________________________________ Date / Time: ___________________