John W. Lee, M.D.
Diplomate of the American Board of Otolaryngology
Ear, Nose, Throat, Head, Neck, and Associated Facial Plastic Surgery

Name:_____ Date: ____/____/____

Please Answer *All* History of the Present Illness Questions:

1. Where is your pain/problem? _____
2. How long have you had this problem? _____
3. What makes this problem better or worse? _____
4. Check yes or no to any of the following symptoms associated with this problem:

Hearing Loss?	☐ Yes ☐ No	Swollen Glands in Neck?	☐ Yes ☐ No
Ringing in Ears?	☐ Yes ☐ No	Mouth Sores?	☐ Yes ☐ No
Pain in Ears?	☐ Yes ☐ No	Coughing?	☐ Yes ☐ No
Drainage in Ears?	☐ Yes ☐ No	Dizziness?	☐ Yes ☐ No
Nasal Drainage?	☐ Yes ☐ No	Watery Eyes?	☐ Yes ☐ No
Sneezing?	☐ Yes ☐ No	Difficulty Swallowing?	☐ Yes ☐ No
Sore Throat?	☐ Yes ☐ No	Hoarseness?	☐ Yes ☐ No

Complete ROS: Are you currently having any of the following? (check yes or no)

Dizziness?	☐ Yes ☐ No	Frequent Urination?	☐ Yes ☐ No
Chest Pain?	☐ Yes ☐ No	Joint Pain?	☐ Yes ☐ No
Shortness of Breath?	☐ Yes ☐ No	Change in Skin Color?	☐ Yes ☐ No
Double Vision?	☐ Yes ☐ No	Bleeding?	☐ Yes ☐ No
Nausea or Vomiting?	☐ Yes ☐ No	Allergies?	☐ Yes ☐ No

Medical History: Have you ever been diagnosed or treated with any of the following? (check all that apply)

☐ Nasal Surgery	☐ Radiation Therapy	☐ Sleep Study	☐ Pacemaker
☐ Sinus Surgery	☐ Daily ASPIRIN Use	☐ Hypothyroid	☐ Liver Disease
☐ Nasal Trauma	☐ Asthma	☐ High Blood Pressure	☐ Anemia
☐ Ear Surgery	☐ Diabetes	☐ Bleeding or bruising easily	☐ Anesthesia Reaction
☐ CAT Scan of Sinus or Head	☐ Emphysema	☐ Heart Attack	☐
☐ Cancer of: _____	☐ Stomach Ulcers	☐ Heart Valve Problem	☐
☐ Chemotherapy	☐ Sleep Apnea	☐ Stroke	☐

Current Medications: (included aspirin, blood thinners, vitamins, herbal, birth control)

_____

List all Surgeries: _____

_____

Allergies: (include allergies to medications, contrast or dyes, latex or iodine)

_____

Family History of:

Bleeding Disorders	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Cardiac Problems	☐ Yes ☐ No

Smoker? 1) If yes Packs per day _____ # of years? _____ 2) Quit ☐ Yes ☐ No What year? _____
3) Never smoked _____ 4) Snuff or Chewing Tobacco ☐ Yes ☐ No 5) Cigar or Pipe? ☐ Yes ☐ No
Do you drink beer, wine or liquor on a daily basis ? ☐ Yes ☐ No

_____ _____ _____
PATIENT'S SIGNATURE PROVIDER'S SIGNATURE DATE