

Name: _____ M F Age: _____ DOB: ___ - ___ - ____
Drew Locandro, MD Andrew Sutton, MD Shatul Parikh, MD Ryan Kauffman, MD Avani Ingley, MD

Primary Care Physician: _____ (none)

Referring Physician/Practice Name: _____ (none or PCP above)

Reason for Visit: (include description of problem, onset, location, frequency, severity, other signs, treatments)

Medical History: (no other medical problems) hypertension heart disease diabetes asthma COPD
↑cholesterol kidney disease allergic rhinitis thyroid disease migraines sleep apnea (CPAP yes no)
cancer _____ _____ _____ _____

Previous Surgery: (none) tonsils adenoids ear tubes ear surgery nasal/sinus surgery vocal cord
thyroid neck surgery _____ _____ _____

Family History: (none) or anything related to visit: _____

Social History: Alcohol: never minimal less than 10/week more than 10/week
Tobacco: never minimal yes ___packs/day x ___yrs quit ___yrs ago (___packs/day x ___yrs)

Current Medications: (none) _____ (see attached)

Drug Allergies: (none) _____

General	Respiratory	Lymphatic/Blood	Gastrointestinal
Weight change <input type="checkbox"/> yes <input type="checkbox"/> no	Cough <input type="checkbox"/> yes <input type="checkbox"/> no	Swollen glands <input type="checkbox"/> yes <input type="checkbox"/> no	Indigestion <input type="checkbox"/> yes <input type="checkbox"/> no
Fever <input type="checkbox"/> yes <input type="checkbox"/> no	Short breath <input type="checkbox"/> yes <input type="checkbox"/> no	Excess bleeding <input type="checkbox"/> yes <input type="checkbox"/> no	Nausea <input type="checkbox"/> yes <input type="checkbox"/> no
Fatigue <input type="checkbox"/> yes <input type="checkbox"/> no	Wheezing <input type="checkbox"/> yes <input type="checkbox"/> no	Excess bruising <input type="checkbox"/> yes <input type="checkbox"/> no	Swallowing prob <input type="checkbox"/> yes <input type="checkbox"/> no

Cardiovascular	Neurologic	Eye	Endocrine
Chest pain <input type="checkbox"/> yes <input type="checkbox"/> no	Headaches <input type="checkbox"/> yes <input type="checkbox"/> no	Eye pain <input type="checkbox"/> yes <input type="checkbox"/> no	Bone pain <input type="checkbox"/> yes <input type="checkbox"/> no
Palpitations <input type="checkbox"/> yes <input type="checkbox"/> no	Lightheaded <input type="checkbox"/> yes <input type="checkbox"/> no	Double vision <input type="checkbox"/> yes <input type="checkbox"/> no	Cold sensitive <input type="checkbox"/> yes <input type="checkbox"/> no
Leg swelling <input type="checkbox"/> yes <input type="checkbox"/> no	Numbness <input type="checkbox"/> yes <input type="checkbox"/> no	Dry eye <input type="checkbox"/> yes <input type="checkbox"/> no	Hair/skin change <input type="checkbox"/> yes <input type="checkbox"/> no

Ear Nose Throat	Allergy	Sleep
Hearing loss <input type="checkbox"/> yes <input type="checkbox"/> no	Sneezing <input type="checkbox"/> yes <input type="checkbox"/> no	Loud snoring <input type="checkbox"/> yes <input type="checkbox"/> no
Tinnitus <input type="checkbox"/> yes <input type="checkbox"/> no	Mouth breathing <input type="checkbox"/> yes <input type="checkbox"/> no	Interrupted <input type="checkbox"/> yes <input type="checkbox"/> no
Vertigo <input type="checkbox"/> yes <input type="checkbox"/> no	Seasonal <input type="checkbox"/> yes <input type="checkbox"/> no	Un-refreshed <input type="checkbox"/> yes <input type="checkbox"/> no
Ear pain <input type="checkbox"/> yes <input type="checkbox"/> no	Allergy shots <input type="checkbox"/> yes <input type="checkbox"/> no	Day sleepiness <input type="checkbox"/> yes <input type="checkbox"/> no
Ear drainage <input type="checkbox"/> yes <input type="checkbox"/> no	Previous testing <input type="checkbox"/> yes <input type="checkbox"/> no	
Sore throat <input type="checkbox"/> yes <input type="checkbox"/> no	results: _____	
Neck mass <input type="checkbox"/> yes <input type="checkbox"/> no		

Please enter: height ___ ft ___ in, weight ___ lbs (staff use: BMI ___ T ___ RR ___ P ___ BP ___ / ___)

Patient/guardian signature _____

(DX min(x2max)x1, est stbx1, est worsx2, newx3, new wkupx4
DATA lab rad proc md dis req MR rev MRx2 view x2 _____ RISK min low mod high)_____