Toledo Clinic ENT
Adult History & Physical
Oliver H. Jenkins, M.D.
Christopher B. Perry, D.O.

Please Fill Out Both Sides of Form

Name: ________________________________ Sex: Male _____ Female _____

Date of Birth: ________________ Age: _____

Primary Care Physician: ____.________________________

Reason for Referral: ____

Onset of Symptoms____

Allergies To Medications____

Allergies to IV Contrast____

Patient History

Do you have: **If yes, please describe:**

Do you have	Yes / No	If yes, please describe
Food Allergies	Yes □ No □	
Seasonal allergies/hay fever	Yes □ No □	
Dizziness	Yes □ No □	
Asthma/Emphysema	Yes □ No □	
Ear infections/surgery	Yes □ No □	# in last 12 months last episode
Hearing problems	Yes □ No □	
Migraine Headaches	Yes □ No □	
Tinnitus (ringing in ears)	Yes □ No □	
Sinus problems	Yes □ No □	
Snoring	Yes □ No □	
Strep throat/tonsillitis	Yes □ No □	# in last 12 months last episode
Acid reflux/gastritis	Yes □ No □	
Bleeding tendencies	Yes □ No □	
Bronchitis/Pneumonia	Yes □ No □	
Blood clots (in the legs or lungs) phlebitis	Yes □ No □	
Arthritis	Yes □ No □	
Diabetes/Hypoglycemia	Yes □ No □	
Eczema	Yes □ No □	
Glaucoma/eye disease	Yes □ No □	
Heart disease/attack	Yes □ No □	
HIV/AIDS/STD	Yes □ No □	
Kidney/Bladder disease	Yes □ No □	
Liver disease/Hepatitis	Yes □ No □	
Lung problems	Yes □ No □	
High Blood Pressure	Yes □ No □	
Psychiatric illness	Yes □ No □	
Rheumatic fever	Yes □ No □	
Seizures/convulsions	Yes □ No □	
Stroke or TIA	Yes □ No □	
Thyroid illness	Yes □ No □	
Tuberculosis	Yes □ No □	
Yeast or fungal infections	Yes □ No □	
Complications with surgery or anesthesia	Yes □ No □	
Are you menstruating	Yes □ No □	Date of last cycle
Are you pregnant	Yes □ No □	
Exposed to tobacco smoke	Yes □ No □	Who___________How much__________
History of Cancer	Yes □ No □	When__________What Kind__________

Current Medications? ____

____

____

____

Over the Counter/Herbal Medications:

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____

____

Surgical History

Type of Surgery	Year of Surgery

Social History			**If yes explain**
Have you or do you use tobacco products	Yes □	No □	Packs per day___ Years___Quit___yrs
Are you around smokers	Yes □	No □	At home___ at work___
Alcohol use	Yes □	No □	How often__________# of drinks_____

Family history:			**If yes, please indicate relationship to patient**:
Asthma	Yes □	No □	
Bleeding tendencies	Yes □	No □	
Cancer	Yes □	No □	
Diabetes	Yes □	No □	
Ear infections	Yes □	No □	
Ear surgeries	Yes □	No □	
Food allergies	Yes □	No □	
Hearing problems	Yes □	No □	
Heart disease	Yes □	No □	
High blood pressure	Yes □	No □	
Seasonal allergies/hay fever	Yes □	No □	
Stroke	Yes □	No □	

Other problems/conditions the physician needs to be aware of:

____

Reviewed by ____________________________________ (staff) Date______________________

Reviewed by ____________________________________ (physician) Date_________________