

**MIDWEST**  
**Ear, Nose & Throat Consultants, Ltd.**

James M. Chow, M.D.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Referring M.D. \_\_\_\_\_

**NEW PATIENT FORM**

**Allergies (Environmental)** \_\_\_\_\_

**Allergies (Medicine)** \_\_\_\_\_

What are your concerns for today's visit?  
\_\_\_\_\_  
\_\_\_\_\_

If pain or headache is your major symptom, how would you grade it on a scale of 1-10. (Please circle)

1 2 3 4 5 6 7 8 9 10

**Past Medical History:**

1) Please check the "Yes" or "No" box to indicate whether you have any of the following illnesses: For "Yes" answers, please explain.

	<u>Yes</u>	<u>No</u>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease/cholesterol problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach or Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy problems/therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Pediatric Patient Only:**

Pregnancy	<input type="checkbox"/> Uncomplicated	<input type="checkbox"/> Complicated	_____
Delivery	<input type="checkbox"/> Uncomplicated	<input type="checkbox"/> Complicated	_____
How is your child's			
a. Growth & Development:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	_____
b. Immunization:	<input type="checkbox"/> Up to date	<input type="checkbox"/> Not up to date	_____

2) Please list any operations (and dates) you have ever had (including tonsils & adenoids):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Please list any current medications (and amount, times per day):

*(including aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

	<u>Yes</u>	<u>No</u>	Please list details below:
Do you smoke? List how much	<input type="checkbox"/>	<input type="checkbox"/>	_____
If no, did you smoke previously?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you drink alcohol? List how much	<input type="checkbox"/>	<input type="checkbox"/>	_____
What type of alcohol do you prefer?			_____
What is your occupation?			_____

**PLEASE TURN OVER**

**MIDWEST**  
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Patient Name: \_\_\_\_\_

James M. Chow, M.D.

**NEW PATIENT FORM**

**Family History:**

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:

If yes, please indicate which relative(s) have the problem

	<u>Yes</u>	<u>No</u>	
Hearing problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problem	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Review of Systems:**

Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:

		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
ALLERGY	sneezing	<input type="checkbox"/>	<input type="checkbox"/>	post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
	environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>			
ENT	ear pain or itch	<input type="checkbox"/>	<input type="checkbox"/>	ear drainage	<input type="checkbox"/>	<input type="checkbox"/>
	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	ear noises	<input type="checkbox"/>	<input type="checkbox"/>
	dizziness	<input type="checkbox"/>	<input type="checkbox"/>	lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>
	sense of smell problem	<input type="checkbox"/>	<input type="checkbox"/>	problem snoring, apnea	<input type="checkbox"/>	<input type="checkbox"/>
	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	throat pain	<input type="checkbox"/>	<input type="checkbox"/>
	throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	throat dryness, itching	<input type="checkbox"/>	<input type="checkbox"/>
RESPIR.	cough	<input type="checkbox"/>	<input type="checkbox"/>	coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
EYES	eye pain	<input type="checkbox"/>	<input type="checkbox"/>	watery or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>
GI	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>
NEURO	headache	<input type="checkbox"/>	<input type="checkbox"/>	passing out	<input type="checkbox"/>	<input type="checkbox"/>
GENERAL	chills	<input type="checkbox"/>	<input type="checkbox"/>	weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>
	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
ENDO	feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>
HEME/LYM	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	sweating at night	<input type="checkbox"/>	<input type="checkbox"/>
	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULO-SKELETAL	joint aches	<input type="checkbox"/>	<input type="checkbox"/>	muscle aches	<input type="checkbox"/>	<input type="checkbox"/>
GU	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	painful urination	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	rash	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>
	itching	<input type="checkbox"/>	<input type="checkbox"/>	skin or hair changes	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH	depression	<input type="checkbox"/>	<input type="checkbox"/>	mental health problems	<input type="checkbox"/>	<input type="checkbox"/>

Signature: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

**PLEASE STOP HERE**