

Patient Name: _____

TO BE COMPLETED BY PATIENT

FAMILY HISTORY: Please check if you have a family history of:								
Yes	No		Yes	No		Yes	No	
		allergies			heart disease			diabetes
		asthma			bleeding			hypertension
		hearing loss			cancer			thyroid problems

HEAD/NECK SYMPTOM REVIEW: Are you currently having:					
Yes	No		Yes	No	
		hearing loss R / L			persistent/recurrent sore throat
		ear pain R / L			persistent skin lesion(s)
		ear drainage R / L			persistent snoring
		ringing R / L			persistent daytime sleepiness
		vertigo			difficulty swallowing
		nasal congestion			painfull swallowing
		post nasal drip			hoarseness or change in voice
		nose bleeds			allergies

Physician Notes
please do not write in this area

DATE: _____

History & Physical Examination (to be completed by the physician)

General:

Ears: (R) _____
(L) _____

Nose: septum _____
turbinates _____
mucosa _____
d/c _____
sinus tenderness _____

Nasopharynx:

Mouth/Oropharynx:

mucosa _____
tonsils _____
tongue _____

Larynx/Hypopharynx:

Neck

Face

CN II-XII

I/P

