Eastern Virginia Medical School
Department of Otolaryngology- Head and Neck Surgery
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New Patient History Form

Name:________________________ Date:_____________________ Chart:_______________

Referring M.D:________________ Primary care M.D:_______________________________

Address:_______________________ Address:_____________________________________

What problems are you having? ____

(Leave box below blank)

What other medical problems do you have?___________________________________

List all previous operations and approximate year. ___________________________

Current medications:____

What medicine are you allergic to?_______________________________________

Do you have environmental allergies (dust, pollen, hay fever, foods, etc….) Please list?

Have you ever smoked? ______Yes _______No If yes, when did you start?__________

Please Check:

_______Cigarettes ______Cigars _______ Pipes _______Tobacco, Chew or Snuff

How many packs per day?_________________ How many years?________________________

Check here if you drink or use?

_____Hard liquor: How much?___Less than ½ oz/day ____1-3 oz/daily___over 3 ozs/daily

_____Beer: How much?____less than 1 bottle a day____1-3 bottles/day___over 3 bottles daily

_____Wine: How much?____less than 1 bottle/day____1-3 bottles/day___over 3 bottles daily

_____Marijuana How often?___________________________________

_____Cocaine: How often?___________________________________

Are there any diseases that run in your family?____
____

What is your occupation? ____

Review of System:

Do you have problems with any of the following:

	Yes	No	If yes, please explain
Fever, weight loss	_____	_____	________________________
Eyes	_____	_____	________________________
Heart(such as chest pains)	_____	_____	________________________
Lungs(breathing)	_____	_____	________________________
Stomach/liver	_____	_____	________________________
Urinary system	_____	_____	________________________
Skin and/or breast	_____	_____	________________________
Nervous disorders	_____	_____	________________________
Diabetes	_____	_____	________________________
Psychiatric problems	_____	_____	________________________
Blood disorders	_____	_____	________________________

Other problems:____

Stop Here : Remainder to be completed by Nurse/M.D

Vital Signs Ht: __________ WT: ____________ BP: ____________________

Exam

Gen. appear: nml__________ Communication: nml_________ Orientation: nml ____________
Head/face overall: nml___________ Facial strength: nml___________
Eye movement: nml_________
Mood/affect: nml_____________ Cranial nerve: nml_______ Chest movement: _________
Ear: TM/EAC: nml______________________ Ext Ear: nml ____________________

Nose: nml ____

OC/OP:nml: ____

NP: nml ____

Neck: nml ____

X-Rays/Labs Reviewed: ____

DXOptions: ____

Plan: ____

Procedure: ______________________________

Indication: ______________________________

Findings: ____

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