PATIENT UPDATE FORM

Date: _____ Patient Name: _____ DOB: _____

Patient Phone: _____ Primary Care Physician: _____

Medical History Update

Medication Allergies—list any new allergies and describe the reactions to your body

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Medication Update—please check the box and follow the instructions provided.

☐ I reviewed my medication list on file at WMENT, and there have been no changes since my last visit.

☐ I provided an updated, detailed medication list to the receptionist.

☐ I have reviewed my medication list on file with WMENT. I have crossed out medications I no longer take and have added any new medications I am taking.

Family Health History

☐ No, there is no new family health history to report.

☐ Yes, there has been a change in my family history.

Please list any new family history changes: _____

Surgical Health History

☐ No, there are no new surgeries to report.

☐ Yes, I have had surgery since my last visit.

Please list any new surgeries: _____

Preferred Pharmacy

Name: _____ City & State: _____ Phone: _____

Social History

Do you currently consume alcohol? ☐ Yes ☐ No How many drinks per week? _____

Do you currently smoke? ☐ Yes ☐ No

- What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____
- How many cigarettes do you smoke per day? _____

Do you currently use any drugs or supplements not prescribed by a physician? ☐ Yes ☐ No

- What other drugs do you take? _____
- How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Do you drink or take caffeine? ☐ Yes ☐ No How much per day? _____

Complete the following if applicable:

Are you planning a pregnancy? ☐ Yes ☐ No Are you pregnant now? ☐ Yes ☐ No

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Do you or have you had chronic problems with any of the following?

Allergies	☐ Y ☐ N	Hearing Loss	☐ Y ☐ N
Anxiety	☐ Y ☐ N	Heartburn	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Heart Disease	☐ Y ☐ N
Asthma	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N
Back Pain	☐ Y ☐ N	Hives	☐ Y ☐ N
Bleeding Problems	☐ Y ☐ N	Hoarseness	☐ Y ☐ N
Coronary Artery Disease	☐ Y ☐ N	Hyperlipidemia	☐ Y ☐ N
Cancer	☐ Y ☐ N	Hypothyroidism	☐ Y ☐ N
Cardiac Arrest	☐ Y ☐ N	Insomnia	☐ Y ☐ N
Cataracts	☐ Y ☐ N	Joint Pain	☐ Y ☐ N
Chest Pain	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N
Congestion	☐ Y ☐ N	Migraines/Headaches	☐ Y ☐ N
Cough	☐ Y ☐ N	Neuropathy	☐ Y ☐ N
Depression	☐ Y ☐ N	Nosebleeds	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N
Diarrhea	☐ Y ☐ N	Rash	☐ Y ☐ N
Dizziness	☐ Y ☐ N	Seizure Disorder	☐ Y ☐ N
Drug/Alcohol Abuse	☐ Y ☐ N	Shortness of Breath	☐ Y ☐ N
Ear Infections	☐ Y ☐ N	Sinus Condition	☐ Y ☐ N
Fainting	☐ Y ☐ N	Skin Cancer	☐ Y ☐ N
Fatigue	☐ Y ☐ N	Stroke	☐ Y ☐ N
Food Allergies	☐ Y ☐ N	Urinary Problems	☐ Y ☐ N
GERD	☐ Y ☐ N	Vision Loss	☐ Y ☐ N

List any other medical problems you have had: _____

ENT-Related Medical History

What is the ***primary*** reason for your visit? _____

Check any of the following symptoms that pertain to the ***primary reason*** for today's visit:

Allergies ☐	Ear Ringing/Noise ☐	Itchy Eyes ☐	Sinus Headache/Pressure ☐
Allergy Testing ☐	Ear Foreign Body ☐	Laceration ☐	Skin Cancer ☐
Bad Breath ☐	Ear Wax ☐	Lip Lesion ☐	Skin Lesion ☐
Bleeding Ear ☐	Enlarged Tonsils ☐	Medication Refill ☐	Sneezing ☐
Broken Nose ☐	Facial Injury ☐	Mouth Lesion ☐	Snoring ☐
Cough ☐	Facial Swelling ☐	Nasal Congestion ☐	Swallowing Problems ☐
Dizziness ☐	Hearing Aid ☐	Neck Mass ☐	Swollen Glands ☐
Dry Mouth ☐	Hearing Loss ☐	Nosebleed ☐	Test Results ☐
Earache ☐	Heartburn ☐	Postnasal Drip ☐	Throat Pain/Soreness ☐
Ear Bleeding ☐	Hoarseness ☐	Rash ☐	Watery Eyes ☐
Ear Drainage ☐	GERD ☐	Runny Nose ☐	Wheezing ☐
Ear Pressure ☐	Imbalance ☐	Sinus Infection ☐	_____ ☐

Other/Comments: _____

_____

Have your symptoms changed since they began? ☐ Increased ☐ Decreased ☐ Unchanged