# MONMOUTH ENT & AESTHETICS – Patient Intake Form

**Patient information (Please Print):**

Name _____ Date of Birth _____
First MI Last

Primary Care Physician: _____ LOCATION/PHONE: _____

PHARMACY: _____ LOCATION/PHONE: _____

**MEDICAL HISTORY:**

List any MEDICATION ALLERGIES: _____

_____

List MEDICATIONS you are CURENTLY taking (**include blood thinners, ibuprofen, aspirin and/or OTC meds**):

_____

_____

_____

**PAST SURGICAL HISTORY:**

Have you had any surgical procedure? ☐ Yes ☐ No Please list: _____

_____

_____

Have you had any anesthesia complications/concerns: ☐ Yes ☐ No If yes, Please explain: _____

_____

Are you Pregnant? ☐ Yes ☐ No How many months? _____ Breast Feeding? ☐ Yes ☐ No

*For pediatric patients, if applicable:* *Daycare* ☐ *Yes* ☐ *No* *Immunizations up to date:* ☐ *Yes* ☐ *No*

**SOCIAL HISTORY: DO YOU...**

Use Herbal Medications/Products: ☐ Yes ☐ No If yes, please list: _____

_____

Use Alcohol:
Beer/Wine/Liquor
How often: _____

Use Tobacco:
Cigarettes/Cigars/Pipe/Snuff/Chew Tobacco?
How much/# of years: _____
If quit, when (year): _____

Use Illicit/Recreational Drugs:
☐ Yes ☐ No

**PATIENT MEDICAL HISTORY: Anything new since last visit (check for yes):**

- ☐ AIDS/HIV related illness
- ☐ Acid Reflux (GERD)
- ☐ Alcoholism
- ☐ Allergies/Hay fever
- ☐ Anemia/Sickle Cell
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth Defects
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Depression
- ☐ Development Delay
- ☐ Diabetes
- ☐ Dizziness/Disequilibrium
- ☐ Ear Pain/Pressure/Drainage
- ☐ Epilepsy/Convulsions
- ☐ Eye Pain/Drainage
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Heart Attack (MI)
- ☐ Heart Conditions
- ☐ Hearing Loss/ Ringing in ears
- ☐ Hepatitis B, C
- ☐ Hoarseness/Sore Throat
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Immune System Disorder
- ☐ Kidney Disease
- ☐ Liver Problems/Jaundice
- ☐ Lung Disease
- ☐ Mental Illness
- ☐ Sinus/Nasal Congestion
- ☐ Sinus/Nasal Obstruction
- ☐ Smell/Taste Disorders
- ☐ Skin Problems
- ☐ Skin Rash/Hives
- ☐ Sleep Disorder
- ☐ Speech Delay
- ☐ Stomach/Bowel Disorders
- ☐ Stridor/Breathing Difficulty
- ☐ Stroke
- ☐ Swallowing Difficulties
- ☐ Thyroid Problems
- ☐ Tuberculosis (T.B.)
- ☐ Weight Loss/Night Sweats

**FAMILY HISTORY: Have any blood relatives had (please indicate which relative):**

☐ Anesthesia Complications: _____
☐ Asthma: _____
☐ Bleeding Disorders: _____
☐ Cancer (Type): _____
☐ CVA/Stroke: _____
☐ Diabetes: _____
☐ Heart Disease: _____
☐ Hearing loss: _____
☐ High Blood Pressure: _____
☐ Migraine: _____
☐ Meniere's Disease: _____
☐ Otosclerosis: _____
☐ Rhematoid Arthritis: _____
☐ Thyroid Problems: _____
☐ Vertigo: _____
☐ Other: _____

**REVIEW OF SYSTEMS: Please check any of the following symptoms which you have had in the *past* or *currently* have:**

| Symptoms | Current | Past | No | Symptoms | Current | Past | No |
|---|---|---|---|---|---|---|---|
| Fever | | | | Palpitations | | | |
| Weight loss | | | | Chest Pain | | | |
| Night Sweats | | | | Shortness of breath | | | |
| Eye Pain | | | | Coughing | | | |
| Eye Drainage | | | | Constipation | | | |
| Itchy Eyes | | | | Diarrhea | | | |
| Blurred or double vision | | | | Heartburn | | | |
| Ear Pain | | | | Painful urination | | | |
| Ear Drainage | | | | Frequent Urination | | | |
| Decrease Hearing | | | | Muscle/Joint Aches | | | |
| Ringing in Ears | | | | Skin Rashes or Hives | | | |
| Dizziness or Disequilibrium | | | | Headaches | | | |
| Nasal Congestion/Obstruction | | | | Learning Disorder | | | |
| Sneezing | | | | Speech Delay | | | |
| Throat Swelling/Fullness | | | | Mental health Problems | | | |
| Sore Throat | | | | Thyroid Condition | | | |
| Hoarseness | | | | Bleeding Problems | | | |

Signature: _____ Date _____