SUPERIOR
Ear, Nose & Throat
Allergy & Audiology

Philip D. Heichel, MD

Name: _____ **Appointment Date**: ____/____/_____

Preferred Name:_____ Preferred Pronouns:_____

Date of Birth: _____ What is or was your occupation? _____

Primary Doctor _____ Referred By: _____ Self _____

What is the main reason for today's visit and current symptoms: _____

_____

_____

For patients under 18 years old, are they up to date with **immunizations**: ☐ Yes ☐ No

Past/Current Medical Diagnosis (Circle if you have ever had the following):

ADHD/ADD	COPD	High Cholesterol
Anemia	Diabetes: Type 1 or Type 2	Hyperthyroidism
Anxiety / Depression	Fibromyalgia	Hypothyroidism
Arthritis	Heart Disease	Migraines
Asthma	Hepatitis	Reflux
Atrial Fibrillation	HIV (Aids)	Seasonal Allergies
Cancer: _____	High Blood Pressure	Sleep Apnea

Other major medical issues: _____

_____

Do you have any personal or family history of reactions/complications with **anesthesia**? : ☐ Yes ☐ No

If yes, please explain: _____

Do you have any personal or family history of **bleeding complications/disorders**? ☐ Yes ☐ No

If yes, please explain: _____

Family History (Please list any known diseases/diagnosis within your family history along with their relationship to you): _____

_____

_____

_____

_____

Preferred Pharmacy: _____ City: _____

(Continued on Back)

FOR OFFICE USE ONLY

Weight: _____ lbs ☐ pt reported ~ Height: _____ ft _____ inches ☐ pt reported

Temperature: _____ F ~ BP: _____/_____ Lt/Rt Arm ~ Electronic/Manual

Medication List

Include prescriptions, over the counter medications (Tylenol, Advil, etc.) and any herbal supplements:

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

Are you allergic to any medications? ☐ Yes ☐ No If so, please list the medication and side effects:

_____

_____

_____

_____

_____

☐ Yes ☐ No Latex Allergies ☐ Yes ☐ No Allergic to Iodine or Contrast Material

Seasonal Allergies: _____

_____

☐ Yes ☐ No Have you ever been allergy tested? If yes, when? _____

Previous Surgical Procedure **Approximate Date**

Ears: _____

Nose: _____

Throat: _____

Neck: _____

Other: _____

Other: _____

Other: _____

Personal History

Have you ever smoked? ☐ Yes ☐ No If yes, how many per day? _____ Number of years: _____

Are you a current smoker? ☐ Yes ☐ No If no, when did you quit: _____

Do you use smokeless tobacco? ☐ Yes ☐ No If yes, explain: _____

Alcohol use: ☐ Never ☐ Occasionally ☐ Daily How much per day? _____

Do you have any history of illicit or medical drug abuse? ☐ Yes ☐ No

If yes, list type and how often (avg. per day/week): _____

If you quit, please list month/year: _____