Zaher Srour, M.D.

Advanced Otolaryngology & Allergy, LLC

Ear, Nose, Throat - Facial Plastic & Reconstructive Surgery

864 Broadway , Hanover , PA , 17331 **www.HanoverENT.com** **Tel:717-632-2221**

MEDICAL HISTORY – ADULT

Name: _____ **M F T Age:** _____ **DOB**:____/____/_____

Reason for Visit: _____

_____ **Height:**_____ **Weight:** _____

Family Doctor: _____ **Referring Doctor:** _____

PLEASE CHECK ☑ WHERE APPLICABLE

General

☐Weakness
☐Fatigue
☐Chills
☐Night Sweats
☐Weight Loss
☐Weight Gain

Gastro-GI

☐Reflux
☐Swallowing difficulty
☐Heartburn
☐Peptic Ulcer
☐Obesity

Ears

R- right **L**-left

☐Drainage
☐Pain/Pressure
☐Itching
☐Hearing Loss
☐Ringing
☐Hearing Aid
☐Dizziness
☐Vertigo

Previous Exposure To:

_____

R L
R L
R L
R L
R L
R L

☐Loud Noises
☐Explosions
☐Firearm
☐Machinery

Mouth

☐Sore Throat
☐Dry Mouth
☐Loss Of Taste
☐Pain
☐Lesion
☐Bleeding
☐Bloody Discharge
☐Painful Swallowing
☐Mouth Breathing
☐Snoring
☐Sleep Apnea
☐CPAP Machine Use
☐T.M.J. Problem

Nose

☐ Sinusitis
☐Congestion
☐Nose blockage
☐Postnasal Drip
☐ Decrease Smell
☐Facial Pressure
☐Nose Trauma
☐Nosebleed
☐Sneezing
☐Runny Nose :
☐Clear
☐Yellow
☐Green

Throat-Voice

☐Hoarseness
☐Change Of Voice
☐Frequent Clearing
☐Foreign Body Sensation in the throat

Neck

☐Pain
☐Lump/Masses
☐Goiter
☐Swollen Glands
☐Thyroid Nodule

Respiratory

☐Cough
☐ Asthma
☐Wheezing
☐Shortness of breath
☐Noisy Breathing

Eyes

☐Blurred Vision
☐Tearing
☐Itching
☐Pain
☐Dryness

Neuro /Psych

☐Seizures
☐Numbness
☐Tremor
☐Anxiety
☐Depression
☐Migraine

Endocrine

☐Cold intolerance
☐Diabetes
☐Hypothyroid
☐Hyperthyroid
☐Cholesterol
☐Triglyceride

Oncology

☐Radiation
☐Chemotherapy
☐Cancer:

Cardiovascular

☐ Blood Pressure
☐Irregular Heart
☐Heart Attack
☐Easy Bruising
☐Easy Bleeding

Infectious :

☐HIV
☐Hepatitis
☐Tuberculosis
☐Transfusion

Skin:

☐Lesions
☐Cancer
☐Hives, Eczema
☐Rosacea
☐Scaring
☐Acne

Other Health Conditions:

PAST MEDICAL & SOCIAL HISTORY

Occupation	Retired Since:
Smoking	NO YES -Started: Stopped Since: Packs per day : □DIP use
Alcohol	□Never □Occasional □Daily
Illegal Drugs	□Never □Occasional □Daily
Allergies	□ **Medication:** □Not Known
Allergy Testing	□Never □ YES Date : where:
Surgeries	□Tonsils □ Adenoids □Ear Tubes □Ear Surgery □Plastic Surgery □Septoplasty □ Sinuses □Thyroid □Neck Surgery Other Surgeries:
Major Illnesses & Hospitalization	

FAMILY HISTORY

Family Status	□Single □Married □ Divorced □Widowed	
You Live	□With Family □Alone □Nursing Home □Retirement Community	
Father	□Alive	□Passed Away Due to :
Mother	□Alive	□Passed Away Due to :
Siblings	□How many :	□Health problems:
Children	□How many :	□Health problems:

*I do acknowledge the receipt of Notice of Privacy Practices for "Advanced Otolaryngology & Allergy, LLC"

*I give my permission to release **FULL** medical information to other individuals:

□ NO □ YES To _____ Relationship: _____

To _____ Relationship: _____

*I give my permission to leave medical information on **answering machine** or **voicemail**: □ NO □ YES

*If you want to specify the information that can be shared with **other people** or on answering machine/voicemail to:_____

*Medication history consent: I authorize any associated physician, physician assistant or delegated staff member or POA permission to view my prescription history from external source. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

LEGAL REPRESENTATIVE: _____ RELATIONSHIP: _____