Dr. Peter Zonakis M.D. Otolaryngology

Patient Name:_________________________________ DOB_____________________

Today's date _________________________________

Please answer all of the following questions:

Family Doctor:_________________________ Referring Doctor:__________________

Why are you here today:____

Have you had previous treatment: Yes_______ No_______

Please List:____

ENT Review of Systems

Ears: Circle Right or left or both

R / L Hearing loss

R / L Ringing in Ear/s

R / L Ear Discharge

____ Dizziness (Spinning sensation)

____Off- Balance

____ Loud Noise Exposure (___ Guns, ____ Job)

Nose:

____Congestion or stuffiness

____ Runny Nose

____ Postnasal Drip

____ Nosebleeds

____ Sinus Infections

____ Breathing Obstruction

____ Abnormality of Smell

Headache:

Where is it located? ______________________

____ Constant

____ Periodic

____ Throbbing

____ Pressure

____ Nausea

____ Sensitive to Light/ Eye symptoms

Throat

____ Sore Throat

____ Difficulty Swallowing

____ Hoarseness

____ Cough

____ Mouth Ulcers

____ Heartburn

Face and Neck

____ Lump in neck

____ Non-Healing sore

____ Change in Mole

____ Scar

____ Pain: Right or Left side

Check if you have had any of the following:

____ Anemia
____ Arthritis
____ Asthma
____ Bleeding Disorder
____ Bronchitis
____ Cancer
____ Cataracts
____ Diabetes
____ Emphysema
____ Glaucoma
____ Hearing Problems
____ Heart Disease
____ Heart Murmur
____ Hepatitis
____ High Blood Pressure
____ High Cholesterol
____ HIV Positive
____ Kidney Disease
____ Malignant Hyperthermia
____ Migraine Headaches
____ Mononucleosis
____ Multiple Sclerosis
____ Pacemaker
____ Prostate Disorder
____ Pneumonia
____ Psychiatric Disorder
____ Seizures
____ Stomach Ulcers
____ Thyroid Disorder
____ Tuberculosis

Other Illnesses: ____

Family History: Please check all that apply

____ Stroke
____ Hearing Loss
____ TB
____ Kidney Disease
____ Heart Disease
____ High Blood Pressure
____ Arthritis
____ Anesthesia Complications
____ Diabetes
____ Cancer
____ Respiratory Disease

Allergies:

____
____

Medications:

____
____

Surgical History:

____
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