Hoover
Ear, Nose and Throat
Associates, P.C.
2116 Data Park
Hoover, AL 35244
205-733-9595
205-733-9599 Fax

Name:_____ Date of Birth:_____ Check one: ☐ Male ☐ Female

In order to ensure adequate medical care, the following is very important. Thank you for completing this form!
If you need additional space (e.g. for medications or allergies), please ask the receptionist for additional pages.

Who is your primary care physician (PCP)?	**Who is the doctor who referred you to Hoover ENT?**
PCP's Name:	Doctor's Name:
PCP's Address:	Doctor's Specialty:
	Doctor's Fax #:
PCP's Fax #:	What pharmacy do you prefer to use?
Would you like us to send your primary care physician clinical notes concerning today's visit? ☐ Yes ☐ No	Pharmacy Street, City and Phone:

What is the **MAIN MEDICAL REASON FOR YOUR VISIT** to Hoover ENT? _____

In the box below, please list all **OPERATIONS OR MAJOR MEDICAL PROCEDURES** that you have had in the past.
(*Examples: tonsillectomy, heart surgery or stent, knee arthroscopy, etc.)*

Procedure	**Year Performed**

In the box below, please list any and all **ADDITIONAL MEDICAL PROBLEMS** that you have had in the past.
Please include: Problems that have caused you to be hospitalized
Problems for which you see a doctor on a regular basis
Problems for which you take regular medication

Diagnosis	**Approximate Year it Started**

Please list all **MEDICATIONS** that you take regularly (prescription, over-the-counter, herbal, other):

Drug Name	**Dosage / Amount**	**How Often**	**Reason you take this medication**
1)			
2)			
3)			
4)			
5)			
6)			
7)			
Do you take a daily aspirin tablet? ☐ Yes ☐ No			

Name: _____ Date of Birth: _____

Please list all **ALLERGIES** that you have to any medications, foods, or other substances, or check ☐ none known:

Substance (medication, food, latex, etc)	What was the adverse reaction?	Was it severe or mild?
1)		
2)		
3)		
4)		

FAMILY HISTORY: If any immediate family have any of the following, please check the box and write which relative has this diagnosis (e.g. mother, son, sister, etc).

☐ Diabetes _____	☐ Asthma _____	☐ Chronic ear disease _____
☐ High blood pressure _____	☐ Allergies _____	☐ Early hearing loss _____
☐ Stroke _____	☐ Chronic sinus infections _____	☐ Bleeding disorders _____
☐ Heart attack _____	☐ Heart failure _____	☐ Problem with anesthesia _____
☐ Other (please list):		☐ Cancer (list type): _____

SOCIAL HISTORY: (Check the box or fill in numbers where applicable)

Alcohol Use: ☐ Daily ☐ Weekly or monthly ☐ Only a few times a year ☐ Never

Tobacco Use: ☐ Use now ☐ Quit (if quit, what year did you quit?_____) ☐ Never used

If you use tobacco products now, please complete the following:

Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Dip/chew ☐ Vape

Number per day:_____ Number of years of tobacco use: _____

Type of Occupation: _____ **Retired?** ☐ Yes ☐ No **Disabled?** ☐ Yes ☐ No

REVIEW OF SYSTEMS: (Please check all of the following that you have had ***in the last six months***)

Constitutional	Ears, Nose & Throat	Gastrointestinal	Psychiatric
☐ Frequent fatigue	☐ Hearing loss	☐ Heartburn or reflux	☐ Memory loss or confusion
☐ Frequent fever	☐ Ringing / other sound in ears	☐ Painful or difficult swallowing	☐ Trouble sleeping
☐ Unexplained weight loss	☐ Ear pain	☐ Food catching in throat	☐ Anxiety
Allergic / Immune	☐ Nasal obstruction	☐ Chronic abdominal pain	☐ Depression or mania
☐ Hives (urticaria) or itching	☐ Non-healing sore in mouth or throat	**Genitourinary**	**Skin / Integument**
☐ Prone to frequent infections		☐ Painful or difficult urination	☐ Unexplained rash
Eyes	☐ New palpable lump in neck	☐ Frequent or uncontrolled urination	☐ Worrisome skin mass
☐ Itchy, red or watery eyes	**Cadiovascular**		**Hematologic/Lymphatic**
☐ New vision loss / double vision	☐ Chest pain (angina)	**Musculoskeletal**	☐ Anemia
☐ Dry eyes	☐ Irregular heartbeat	☐ Joint pain or arthritis	☐ Easy bleeding or bruising
☐ Glaucoma	**Pulmonary**	☐ Unexplained muscle weakness	☐ Enlarged glands or lymph nodes
☐ Cataracts (cloudy lens in eye)	☐ Frequent cough	**Neurologic**	**Endocrine**
	☐ Shortness of breath	☐ Frequent headaches	☐ Diabetes or high blood sugar
	☐ Wheezing	☐ Numbness or tingling	☐ Thyroid disease
	☐ Snoring	☐ Seizures	
		☐ Loss of coordination	**Other:**
		☐ Slurred speech	

Name: _____ Date of Birth: _____

Please complete this page only if you require additional space.

Please list any ***additional*** **MEDICATIONS** that you take regularly (prescription, over-the-counter, herbal, other):

Drug Name	Dosage / Amount	How Often	Reason you take this medication:
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
Others:			

Please list any ***additional*** **ALLERGIES** that you have to any medications, foods, or other substances:

Substance (medication, food, latex, etc)	What was the adverse reaction?	Was it severe or mild?
5)		
6)		
7)		
8)		

Is there ***any additional information*** regarding your health of which you would specifically like to make us aware?