



EAR, NOSE & THROAT OF FREEHOLD, LLC

MARK ROESSLER, D.O., F.A.O.C.O.

Patient Name: _____ Age: _____ Birth Date: ____/____/____

Occupation: _____ Referring Doctor: _____

REASON FOR VISIT: _____

MEDICAL HISTORY: (check any you have had or are currently experiencing)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Disc Problems	<input type="checkbox"/> Blood Disorders
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Lupus	<input type="checkbox"/> Circulation Problems
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anemia
<input type="checkbox"/> Bladder Disease	<input type="checkbox"/> T.B.	<input type="checkbox"/> Depression	<input type="checkbox"/> Skins Diseases
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cough	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> HIV
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Frequent Colds/Sore Throats	<input type="checkbox"/> Headache/Migraines	<input type="checkbox"/> Other:
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Hearing Loss	
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Numbness/Tingling	
<input type="checkbox"/> Measles	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Neuralgia	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Cancer (type/location)	<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Stroke	

FAMILY HISTORY: (check the box corresponding to diseases encountered by any blood relative)

<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cancer(type/treatment)
<input type="checkbox"/> Migraines	<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Allergies	<input type="checkbox"/> Lupus	
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> T.B.	<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Alcohol/Drug Abuse	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hearing Loss	
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Blood Clots		

ALLERGIES: _____

Are you allergic to Latex? Yes / No

MEDICATIONS: (include type and dose of all Rx, vitamins and over-the-counter products)

1.)	6.)	11.)
2.)	7.)	12.)
3.)	8.)	13.)
4.)	9.)	14.)
5.)	10.)	15.)

SURGERIES: (date / reason) _____

Do you require antibiotics prior to dental work? Yes / No

SOCIAL HISTORY:

Do you consume alcohol? Yes / No

If yes, please complete the following:

Type of Alcohol	How Much?	How Often?

Have you ever used tobacco in any form? Yes / No

If yes, please complete the following:

Type of Tobacco	From Year	To Year
Cigarettes per day:		
Other (list type):		

Are you exposed to second hand smoke? Yes / No

Are there any pets in the house? Yes / No

Do you, or have you, ever used illegal drugs? Yes / No If yes, please list type and amount: _____

Quit / Year: _____

PATIENT SIGNATURE: _____ **DATE:** _____

PHYSICIAN SIGNATURE: _____

NOTES: