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)

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

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

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

ALLERGIES: ______________________

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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) ______________________

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____

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

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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: