Conway Physicians Group
Otolaryngology
Carolina Bays ENT

Darin Sutton, MD
Peter Bondy, MD

DATE: _____

NAME: _____ CHART #: _____

REFERRING PHYSICIAN: _____

SPOUSE'S NAME: _____ DOB: _____

CHILDRENS NAMES:

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

PATIENT OCCUPATION: _____

SPOUSE'S OCCUPATION: _____

MEDICAL HISTORY

Please check all that apply and explain below

	SELF	MOTHER	FATHER	GRANDPARENTS
Hypertension				
Heart Disease				
Stroke				
Diabetes				
Asthma				
Reflux				
Seizures				
Hepatitis				
HIV Disease				
Lung Disease				
Kidney Disease				
Bleeding Disorders				
Cancer				

Medical History Explanation:

_____

_____

_____

_____

Medical/Family/Social History:	Level 1 & 2 – None	Level 3 – 1/3	Level 4 – New 3/3, Est. 1/3

SURGICAL HISTORY (Type & Year): _____

_____

_____

CURRENT MEDICATIONS: _____

_____

_____

MEDICATION ALLERGIES: _____

_____

_____

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LAST IMMUNIZATION: _____

Do you....

SMOKE? Yes No How Much? _____ DRINK ALCOHOL? Yes No How Much? _____

USE DRUGS? Yes No What Kind? _____ How Much? _____

PLEASE CHECK WHICH SYMPTOMS YOU FREQUENTLY EXPERIENCE

General:	____ Weight Loss How Much? _____	____ Fatigue	____ Sleep Disturbances
Neuro:	____ Spinning Sensation	____ Unsteadiness	____ Headaches
ENT:	____ Hearing Loss	____ Tinnitus	____ Hoarseness
Eyes:	____ Visual Changes	____ Excessive Tearing	____ Dry Eyes
Lungs:	____ Shortness of Breath	____ Cough	____ Wheezing
Heart:	____ Chest Pain	____ Palpitations	____ Heart Murmur
GI:	____ Swallowing Difficulties	____ Abdominal Pain	____ Nausea / Vomiting
GU:	____ Frequent Urination	____ Blood in Urine	____ Difficulty Urinating
Skin:	____ Excess Dryness	____ Easy Bruising	____ Swelling / Masses
Immune:	____ Hay Fever / Seasonal Allergies	____ Frequent Infections	____ Food Sensitivities
M/S:	____ Limited Joint Movement	____ Joint Swelling / Pains	____ Muscle Spasms
Endocrine:	____ Hot / Cold Flashes	____ Weight Fluctuations	____ Mood Swings
Heme:	____ Swollen Lymph Nodes	____ Prolonged Bleeding	____ Blood Clots
Psych:	____ Hallucinations	____ Depression	

Level 1 – None	Level 2 – 1 System	Level 3 – 2-9 Systems	Level 4 – 10+ Systems

IS THERE ANY INFORMATION YOU WISH TO SHARE? _____

_____

_____

PRIMARY PHYSICIAN: _____

OTHER PHYSICIANS: _____

_____

_____

REASON FOR TODAY'S VISIT: _____

_____

HAVE YOU SEEN ANOTHER OTOLARYNGOLOGIST FOR THE SAME PROBLEM IN THE PAST? _____

DO NOT WRITE BELOW THIS LINE

DATE: _____ REVIEWED BY _____, MD

DATE: _____ REVIEWED BY _____, MD

DATE: _____ REVIEWED BY _____, MD