BOSTON ENT ASSOCIATES ***Today's Date:_____***

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Name:_____ Date of Birth:_____ Age:_____

Primary Care Physician: _____ PCP Hospital Affiliation:_____

Email (you will receive an invitation to our patient portal): _____

What is your primary reason for today's visit?_____

MEDICAL HISTORY

Do you have a history of (please circle): ***High blood pressure Asthma Heart Disease Diabetes NONE***

Please list any other medical conditions you may have: ☐ ***no medical conditions***

Operations of the ears, nose, throat, head or neck: ☐ ***none***

Do you have a pacemaker or any other metal implants?

MEDICATIONS

List current medications (or provide list if available): ☐ ***no current medications***

Please list ALLERGIES to medications or anesthesia: ☐ ***no known allergies***

Your doctor will send your prescriptions electronically to your pharmacy.
Pharmacy Information: ***CVS Walgreens Rite-Aid Costco Target Other*:_____**
***Street/City*:_____**

SOCIAL and FAMILY HISTORY

Do you currently drink alcohol?	**Y N**	**How much?**	
If no, did you drink alcohol in the past?	**Y N**	**How much?**	
History of loud noise exposure?	**Y N**	**If yes, describe:**	
Do you use e-cigarettes or vape?	**Y N**	**If so, how much?**	
Do you currently smoke?	**Y N**	**If so, how much?**	
Have you smoked in the past?	**Y N**	**If so, how much?**	**Quit date:_____**

Do you have a family history of hearing loss under age 65, cancer of the head and neck, or bleeding disorders, or reactions to general anesthesia? Or NONE

Please list your height and weight: ____ ft. ____ inches _____ lbs.

Do you currently experience any of the following (please circle):

Fever Unexplained weight loss Unexplained weight gain Double Vision Itching eyes

Hearing Loss Frequent nosebleeds Sore throat Snoring Dry Mouth Difficulty Swallowing Hoarseness

Headaches Seizures Chest Pain Palpitations Wheezing Shortness of Breath

Heartburn Nausea Easy Bruising Bleeding problems Depression Anxiety Muscle Aches Joint Pain

Rashes Itching Dry Skin Heat/Cold Intolerance