GREATER KNOXVILLE
EAR NOSE & THROAT

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PATIENT MEDICAL INFORMATION SHEET

Why have you come to see our doctor today? _____

Please write down any medications that you are currently taking, along with doses and schedules:

_____

Please write down any medications to which you have had a reaction or allergy:

_____

Have you ever had surgery? If so where? What?

_____

In the boxes below, please check symptoms that occur to you often or have recently begun:

- ☐ WEIGHT GAIN/ LOSS
- ☐ FEVER
- ☐ NIGHT SWEATS
- ☐ LOSS OF APPETITE
- ☐ FATIGUE
- ☐ CHANGE IN SKIN/ HAIR
- ☐ RASHES
- ☐ BRUISING
- ☐ DOUBLE VISION
- ☐ DRY EYES
- ☐ HEARING LOSS
- ☐ NOSE BLEEDS
- ☐ LOSS OF TASTE
- ☐ LOSS OF SMELL
- ☐ EAR PAIN
- ☐ RINGING IN EARS
- ☐ FREQUENT SORE THROATS
- ☐ HOARSENESS
- ☐ DRY MOUTH
- ☐ FREQUENT EAR INFECTIONS
- ☐ SNEEZING/ RUNNY NOSE
- ☐ CHANGE IN VISION
- ☐ COUGHING UP BLOOD
- ☐ WHEEZING
- ☐ SNORING
- ☐ IRREGULAR HEARTBEAT
- ☐ SHORTNESS OF BREATH
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ PAINFUL SWALLOWING
- ☐ INDIGESTION
- ☐ DIFFICULTY SWALLOWING
- ☐ VOMITING BLOOD
- ☐ BLOODY STOOLS
- ☐ FREQUENT URINATION
- ☐ BLOOD IN URINE
- ☐ PAINFUL URINATION
- ☐ SORE JOINTS
- ☐ PAIN IN MUSCLES
- ☐ WEAK MUSCLES
- ☐ SEIZURES
- ☐ NUMBNESS/ PARALYSIS
- ☐ FEELINGS OF DEPRESSION
- ☐ HEAT/COLD INTOLERANCE
- ☐ ENLARGED LYMPH NODES

Please check the box next to any of the following medical conditions with which you have been diagnosed:

- ☐ HYPERTENSION
- ☐ DIABETES MELLITUS I
- ☐ DIABETES MELLITUS II
- ☐ HEART DISEASE
- ☐ ANGINA
- ☐ ARRYTHMIAS
- ☐ ASTHMA
- ☐ COPD
- ☐ EMPHYSEMA
- ☐ TUBERCULOSIS
- ☐ ESOPHAGEAL REFLUX
- ☐ HEPATITIS
- ☐ DEPRESSION
- ☐ ANEMIA
- ☐ LIVER DYSFUNCTION
- ☐ KIDNEY STONES
- ☐ CHRONIC RENAL FAILURE
- ☐ DIALYSIS
- ☐ PROSTATE ENLARGEMENT
- ☐ THYROID DISEASE
- ☐ GOUT
- ☐ ARTHRITIS
- ☐ LUPUS/ SCLERODERMA
- ☐ SEIZURES
- ☐ MULTIPLE SCLEROSIS
- ☐ PARALYSIS
- ☐ MUSCLE DISEASE
- ☐ ALLERGIC RHINITIS
- ☐ IMMUNE ABNORMALITIES
- ☐ AIDS
- ☐ GLAUCOMA
- ☐ BLEEDING DISORDERS
- ☐ HEARING LOSS
- ☐ PEPTIC ULCER DISEASE
- ☐ STROKE
- ☐ CANCER: _____
- ☐ OTHER:_____
- ☐ OTHER
- ☐ NONE

Please check the box next to any diseases that run in your immediate family (parents, grandparents, siblings)

- ☐ HYPERTENSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ LUNG DISEASE
- ☐ CANCER
- ☐ ARTHRITIS
- ☐ BLEEDING PROBLEMS
- ☐ HEARING LOSS
- ☐ OTHER: _____

COVID VACCINE 1ST DOSE: DATE_____ 2ND DOSE: DATE_____ BOOSTER: DATE_____

FLU VACCINE: YEAR _____ PNEUMONIA VACCINE: YEAR _____

Please check the box if you use the following:

- ☐ CIGARETTES:CIRCLE ONE CURRENT? FORMER?
- ☐ ALCOHOL
- ☐ DRUGS
- ☐ OTHER TOBACCO

PLEASE SIGN YOUR NAME: _____ TODAY'S DATE: _____