

**DRS. BERGHASH & LANZA, P.L., d/b/a SOUTH COAST EAR, NOSE & THROAT  
MEDICAL INFORMATION SHEET**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

FAMILY DOCTOR/REFERRED BY \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

REASON FOR VISIT \_\_\_\_\_

HOW LONG \_\_\_\_\_ HOW SEVERE \_\_\_\_\_

PREVIOUS TREATMENT FOR THIS PROBLEM \_\_\_\_\_

IF FEMALE, ARE YOU PREGNANT?  YES  NO ARE YOU ALLERGIC TO LATEX?  YES  NO

DO YOU TAKE ANY HERBAL OR HOMEOPATHIC REMEDIES?  YES  NO IF SO, WHAT: \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ LOCATION: \_\_\_\_\_

**EAR/NOSE/THROAT (PLEASE CHECK ALL THAT APPLY)**

- |                           |  |  |  |  |
|---------------------------|--|--|--|--|
| <b>EAR</b>                | <input type="checkbox"/> PAIN          | <input type="checkbox"/> VERTIGO           | <input type="checkbox"/> RINGING             | <input type="checkbox"/> HISTORY OF INFECTION  |
|                           | <input type="checkbox"/> WAX IMPACTION | <input type="checkbox"/> DRAINAGE          | <input type="checkbox"/> HEARING LOSS        | <input type="checkbox"/> NOISE EXPOSURE        |
| <b>NOSE</b>               | <input type="checkbox"/> BLEEDING      | <input type="checkbox"/> OBSTRUCTION       | <input type="checkbox"/> PREVIOUS INJURY     |  |
|                           | <input type="checkbox"/> CONGESTION    | <input type="checkbox"/> STUFFINESS        | <input type="checkbox"/> POST NASAL DRAINAGE |  |
| <b>THROAT</b>             | <input type="checkbox"/> SORE THROAT   | <input type="checkbox"/> COUGH             | <input type="checkbox"/> HOARSENESS          | <input type="checkbox"/> DIFFICULTY SWALLOWING |
| <b>ALLERGY/<br/>SINUS</b> | <input type="checkbox"/> HEADACHES     | <input type="checkbox"/> FACIAL PRESSURE   | <input type="checkbox"/> ASTHMA              | <input type="checkbox"/> SNEEZING              |
|                           | <input type="checkbox"/> INFECTIONS    | <input type="checkbox"/> ITCHY/WATERY EYES |  |  |

**SYSTEM REVIEW (PLEASE CHECK ALL THAT APPLY)**

- |                             |   |   |   |
|-----------------------------|---|---|---|
| <b>SLEEP PATTERNS</b>       | <input type="checkbox"/> SNORING              | <input type="checkbox"/> DAYTIME FATIGUE      | <input type="checkbox"/> AIRWAY OBSTRUCTION   |
| <b>CONSTITUTIONAL</b>       | <input type="checkbox"/> FEVER                | <input type="checkbox"/> WEIGHT LOSS          | <input type="checkbox"/> WEIGHT GAIN          |
| <b>SKIN</b>                 | <input type="checkbox"/> LESIONS              | <input type="checkbox"/> SKIN CANCER          | <input type="checkbox"/> RASHES/ ITCHES       |
| <b>EYES</b>                 | <input type="checkbox"/> GLAUCOMA             | <input type="checkbox"/> VISUAL CHANGES       | <input type="checkbox"/> DOUBLE VISION        |
| <b>CARDIOVASCULAR</b>       | <input type="checkbox"/> HEART ATTACK         | <input type="checkbox"/> HEART DISEASE        | <input type="checkbox"/> CHEST PAINS          |
|                             | <input type="checkbox"/> IRREGULAR HEART BEAT |   | <input type="checkbox"/> HIGH BLOOD PRESSURE  |
| <b>RESPIRATORY</b>          | <input type="checkbox"/> PNEUMONIA            | <input type="checkbox"/> EMPHYSEMA            | <input type="checkbox"/> BRONCHITIS           |
| <b>GASTROINTESTINAL</b>     | <input type="checkbox"/> ULCERS/ COLITIS      | <input type="checkbox"/> NAUSEA               | <input type="checkbox"/> HIATAL HERNIA/REFLUX |
| <b>G/U</b>                  | <input type="checkbox"/> KIDNEY STONES        | <input type="checkbox"/> RECURRENT UTI        | <input type="checkbox"/> BLOOD IN URINE       |
| <b>MUSCULOSKELETAL</b>      | <input type="checkbox"/> NECK INJURY          | <input type="checkbox"/> RHEUMATOID ARTHRITIS |   |
| <b>NEUROLOGICAL</b>         | <input type="checkbox"/> DIZZINESS            | <input type="checkbox"/> STROKE               | <input type="checkbox"/> MIGRAINES            |
|                             |   |   | <input type="checkbox"/> WEAKNESS/NUMBNESS    |
| <b>ENDOCRINE</b>            | <input type="checkbox"/> THYROID              | <input type="checkbox"/> SWEATING             | <input type="checkbox"/> DIABETES             |
| <b>ALLERGIC/IMMUNOLOGIC</b> | <input type="checkbox"/> SKIN RASHES          | <input type="checkbox"/> INFECTIONS           | <input type="checkbox"/> ALLERGY INJECTIONS   |

**\*PLEASE TURN OVER AND COMPLETE OTHER SIDE\***

**PRESENT MEDICATIONS (PLEASE LIST DOSAGE AND FREQUENCY)**

_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY
_____	_____ TIME/S PER DAY

**PAST HISTORY (PLEASE CHECK ALL THAT APPLY)**

<b>CHILDHOOD ILLNESSES</b>	<input type="checkbox"/> MEASLES	<input type="checkbox"/> MUMPS	<input type="checkbox"/> CHICKEN POX
<b>IMMUNIZATIONS</b>	<input type="checkbox"/> TETANUS	<input type="checkbox"/> MMR	<input type="checkbox"/> DPT
<b>MAJOR ILLNESSES/INJURIES</b> (PLEASE LIST)	_____	APPROXIMATE DATE	_____
	_____	APPROXIMATE DATE	_____
	_____	APPROXIMATE DATE	_____
<b>SURGERIES/OPERATIONS</b> (PLEASE LIST)	_____	APPROXIMATE DATE	_____
	_____	APPROXIMATE DATE	_____
	_____	APPROXIMATE DATE	_____

**FAMILY HISTORY (PLEASE CHECK ALL THAT APPLY)**

<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> THYROID	<input type="checkbox"/> HEARING LOSS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEAD/NECK CANCER
<input type="checkbox"/> BLEEDING DISORDERS		<input type="checkbox"/> ANESTHESIA PROBLEMS

**SOCIAL HISTORY (PLEASE CHECK ALL THAT APPLY)**

TOBACCO     NONE     CHEWING     QUIT \_\_\_\_\_ YEARS AGO    \_\_\_\_\_ PACKS/DAY FOR \_\_\_\_\_ YEARS

CAFFEINE     NONE     YES    circle amount    1-3 cups/beverages    4-6 cups/beverages    7 or more cups/beverages

ALCOHOL     NONE     RARE     SOCIAL    AMOUNT \_\_\_\_\_

DRUG USE     NONE     YES    \_\_\_\_\_

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**PHYSICIAN USE ONLY: REVIEWED WITH PATIENT**

_____	_____	_____	_____
Initials/Date	Initials/Date	Initials/Date	Initials/Date