Otolaryngology Intake Form

Patient Information

Patient Name: _____ Social Security #: _____

Today's Date: _____ Date of Birth (MM/DD/YY): _____ Preferred Language: _____

Phone: _____ Email: _____

Address: _____

Primary Care Provider: _____ Referring Provider: _____

Interpreter Needed (☐ Yes/☐ No): _____ Sex: _____

Reason for Visit/Chief Complaint: _____

Height: Weight: Other:

Review of Symptoms (Check all that apply)

Constitutional:	☐ Fever ☐ Chills ☐ Change in weight ☐ Fatigue ☐ Malaise ☐ Night sweats ☐ Change in sleep pattern ☐ Other:_____
Eyes:	☐ Double vision ☐ Change in vision ☐ Blurry vision ☐ Light sensitivity ☐ Eye discomfort ☐ Eye discharge ☐ Dry eyes ☐ Increased production of tears ☐ Seeing flashes ☐ Other:_____
Ears:	☐ Ear pain ☐ Ear discharge ☐ Ear pressure ☐ Change in hearing ☐ Tinnitus ☐ Vertigo /Dizziness ☐ Other: _____
Nose:	☐ Nasal discharge ☐ Nasal congestion ☐ Nose bleeds ☐ Nose pain ☐ Nasal obstruction ☐ Decreased sense of smell ☐ Postnasal drip ☐ Sinus infections ☐ Sneezing ☐ Other: _____
Mouth:	☐ Mouth pain ☐ Swelling of the lips/tongue ☐ Dry mouth ☐ Change in taste ☐ Sores in the mouth ☐ Teeth pain ☐ Mouth lesion ☐ Other: _____
Neck:	☐ Neck mass ☐ Neck pain ☐ Decreased range of motion ☐ Other: _____
Cardiovascular:	☐ Passing out ☐ Chest pain ☐ Palpitations ☐ Edema with exertion ☐ Shortness of breath ☐ Other: _____
Respiratory:	☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Stridor ☐ Voice change ☐ Change in phlegm color ☐ Coughing up blood ☐ Chest congestion ☐ Other: _____
Neurological:	☐ Headache ☐ Numbness in extremities ☐ Weakness in extremities ☐ Lack of coordination ☐ Dizziness ☐ Vertigo ☐ Facial weakness ☐ Facial numbness ☐ Other:_____
Endocrine:	☐ Excessive thirst ☐ Fatigue ☐ Cold intolerance ☐ Flushing ☐ Heat intolerance ☐ Deepening of the voice
Hematologic/ Lymphatic:	☐ Easy bruising ☐ Easy bleeding ☐ Enlarged lymph nodes ☐ Other: _____
Allergic/ Immunologic:	☐ Hives ☐ Throat swelling ☐ Tongue swelling ☐ Facial swelling ☐ Wheezing ☐ Itchy eyes ☐ Seasonal allergies ☐ Food intolerance ☐ Other: _____

Past Medical History (Check all that apply)

- ☐ Allergic rhinitis
- ☐ Chronic rhinosinusitis
- ☐ Nasal polyps
- ☐ Asthma
- ☐ COPD
- ☐ OSA (sleep apnea)
- ☐ Hypertension
- ☐ Coronary artery disease
- ☐ Stroke/TIA
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ GERD/LPR
- ☐ Autoimmune disease
- ☐ Bleeding disorder
- ☐ Clotting disorder
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Cancer (specify):_____
- ☐ Migraine
- ☐ Ménière's disease
- ☐ Hearing loss
- ☐ Prior head/neck radiation
- ☐ Other conditions: _____

Past Surgical History—Head and Neck (Check all that apply)

- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Septoplasty
- ☐ Turbinate reduction
- ☐ Rhinoplasty
- ☐ FESS (sinus surgery)
- ☐ Balloon sinuplasty
- ☐ Nasal polyp removal
- ☐ Tympanostomy tubes
- ☐ Tympanoplasty
- ☐ Mastoidectomy
- ☐ Stapedectomy/ossicular surgery
- ☐ Cochlear implant
- ☐ Parotidectomy
- ☐ Submandibular gland excision
- ☐ Thyroidectomy
- ☐ Neck dissection
- ☐ Laryngoscopy/microlaryngoscopy
- ☐ Tracheostomy/airway surgery
- ☐ Skull base surgery
- ☐ Head/Neck cancer surgery

Other Surgeries (Non-ENT or not listed above)

Procedure	Laterality	Date	Hospital	Notes

Recent Hospitalizations and Prior Trauma

Hospitalized in the last six months (☐ Yes/☐ No) Reason and dates:_____

Prior head and neck trauma (Describe with dates): _____

Allergies

☐ No known food/environmental allergies

All Food/Environmental Allergies

Allergen	Reaction	Severity	Date/Notes

Prior Allergy Testing/Immunotherapy

Testing type (☐ Skin prick ☐ Serum IgE) Date and location:_____

Notable results (sensitizations):_____

Allergen immunotherapy (☐ Never ☐ Past ☐ Current)

If yes, start date and duration: _____

Hearing History

Prior hearing test/audiogram (date):_____ Location/clinic: _____

Hearing aids (☐ None ☐ Left ☐ Right ☐ Bilateral) Brand/model (if known): _____

Assistive devices (☐ Cochlear implant ☐ BAHA) Side (☐ Left ☐ Right)

Recent Imaging (last two years)

☐ CT sinus	☐ CT temporal bones	☐ CT neck	☐ MRI brain
☐ MRI IACs	☐ MRI neck	☐ Thyroid/Neck ultrasound	☐ Other:_____

Date(s): _____ Location/facility: _____

Do you have images/a disc? (☐ Yes/☐ No)

OTC Allergy Medications in Use

☐ Oral antihistamine (cetirizine/loratadine/fexofenadine)
☐ Intranasal antihistamine (azelastine/olopatadine)
☐ Decongestant (pseudoephedrine/phenylephrine)
☐ Eye allergy drops
☐ Intranasal steroid (fluticasone/mometasone/budesonide)
☐ Leukotriene modifier (montelukast)
☐ Intranasal ipratropium
☐ Saline spray

Other OTC Medication/Supplements

Name	Dose	Frequency	Indication

Nasal saline rinses (☐ Yes/☐ No): _____ Frequency/technique (e.g., neti pot/NeilMed®): _____

Social/Exposure History

Tobacco (☐ Never ☐ Former ☐ Current) Packs/day and years or quit date: _____

If 'Former' or 'Current', what kind (☐ Cigarette ☐Cigar ☐Oral) ☐Other: _____

Vaping/e-cigarettes (☐ Never ☐ Former ☐ Current) Frequency/type: _____

Alcohol use: _____ Recreational drugs: _____

Occupation: _____ Noise/dust/chemical exposure: _____

_____

Signature

Patient/Guardian Signature: _____ Date: _____