FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

ENT

Name ______________________________ **Date of Birth** ______________________

Personal Health History	
Check if you have had any of the following	
☐ Autoimmune Disorder	☐ Obstructive Sleep Apnea
☐ Barrett's Esophagus	☐ Sjorgen's Disease
☐ Esophageal Stricture	☐ Systemic Lupus Erythematous
☐ Acoustic Neuroma	☐ Respiratory Papillomatosis
☐ Acute Oitis Media (Ear Infection)	☐ Sialodenitis
☐ Allergic Rhinitis	☐ Sialolithiasis
☐ Branchial Cleft Cyst	☐ Singer's Nodes
☐ Cholesteatoma	☐ Sinusitis
☐ Deviated Nasal Septum	☐ Stenosis of Trachea
☐ Disorder of Ear, Nose or Throat	☐ Subglottis Stenosis
☐ Enlargement of Tonsil or Adenoid	☐ Thyroglossal Duct Cyst
☐ Eustachian Tube Disorder	☐ Thyroid Nodule
☐ Fracture of Facial Bones	☐ Tinnitus
☐ Fracture of Nasal Bones	☐ Tonsilitis
☐ Parathyroid Disorder	☐ Ulcer of Mouth
☐ Macular Degeneration	☐ Multiple Sclerosis
☐ Amyotrophic Lateral Sclerosis	☐ Glaucoma
☐ Cataract	☐ Retinal Detachment
☐ Loss of Sense of Smell	☐ Vertigo
☐ Mastoiditis	☐ Vocal Cord Paralysis
☐ Nasal Obstruction	☐ Other

Previous Surgical Procedures	
Check if you have had any of the following	
☐ Adenoidectomy	☐ Nasal Septoplasty
☐ Nasal Fracture Repair	☐ Parathyroidectomy
☐ Rhinoplasty	☐ Reduction of Nasal Turbinates
☐ Endoscopic Sinus Surgery	☐ Acoustic Neuroma Removal
☐ Cervical Lymph Node Removal	☐ Cataract Repair
☐ Esophagectomy	☐ Repair of Prominent or Protruding Ear
☐ Oral Cavity Lesion Removal	☐ Stapedectomy
☐ Submandibular Gland Removal	☐ Thyroidectomy
☐ Thyroglossal Cyst Removal	☐ Retinal Repair
☐ Blepharoplasty	☐ Laryngectomy
☐ Tracheotomy	☐ Tympanotomy
☐ Mastoidectomy	☐ Uvulopalatopharyngoplasty
☐ Modified Radical Neck Dissection	☐ Other
☐ Myringotomy With Tube Placement	☐ Other

Social History				
Do you drive during the day? ☐ Yes ☐ No				
Do you drive during the night? ☐ Yes ☐ No				
Family History				
Check all that apply				
	Mother	Father	Brother	Sister
☐ Oitis Media (Ear Infection)				
☐ Sinusitis				
☐ Smoking				

Pediatric Health History	
Check if you have had any of the following	
☐ Cleft Lip	☐ Oitis Media (Ear Infection)
☐ Cleft Palate	☐ Other

Patient/Guardian Signature: ______________________ Date: ______________________