Gainesville ENT and Allergy Associates

Patient name:	DOB:

Please circle yes or no to indicate any symptoms that you are CURRENTLY experiencing:

Symptom				Symptom			
chills	:	yes	no	irregular heartbeat	:	yes	no
fever	:	yes	no	hypertension	:	yes	no
weight loss	:	yes	no	valve problem	:	yes	no
				heart disease	:	yes	no
headache	:	yes	no				
				liver disease	:	yes	no
eyesight problems	:	yes	no	difficulty urinating	:	yes	no
glasses/contacts	:	yes	no				
glaucoma	:	yes	no	arthritis	:	yes	no
				artificial joint	:	yes	no
ringing in ears	:	yes	no				
discharge from ears	:	yes	no	dizziness	:	yes	no
hearing loss	:	yes	no	neurological disease	:	yes	no
wears hearing aids	:	yes	no				
earache	:	yes	no	rash or itching	:	yes	no
				skin cancer	:	yes	no
nose bleed	:	yes	no				
nasal congestion	:	yes	no	anxiety	:	yes	no
allergies/hay fever	:	yes	no	depression	:	yes	no
snoring	:	yes	no				
				thyroid disorder	:	yes	no
mouth sores	:	yes	no	diabetes	:	yes	no
hoarseness	:	yes	no				
loose/broken teeth	:	yes	no	anemia	:	yes	no
difficulty swallowing	:	yes	no	bruising/bleeding	:	yes	no
dentures	:	yes	no	swollen glands	:	yes	no
				taking blood thinners	:	yes	no
wheezing	:	yes	no	religious needs regarding			
chronic cough	:	yes	no	blood transfusion	:	yes	no
coughing up blood	:	yes	no				
diagnosed sleep apnea	:	yes	no	HIV	:	yes	no
				hepatitis	:	yes	no
shortness of breath	:	yes	no	MRSA	:	yes	no
pacemaker	:	yes	no				