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PHYSICIAN PAVILION AT TRIPOINT MEDICAL CENTER
7580 AUBURN ROAD, #103
CONCORD, OH 44077

PHYSICIAN PAVILION AT WEST MEDICAL CENTER
36060 EUCLID AVENUE, #201
WILLOUGHBY, OH 44094

MADISON MEDICAL CAMPUS
6270 NORTH RIDGE ROAD
MADISON, OH 44057

GENERAL INFORMATION:

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

Name: LAST NAME FIRST NAME MI Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Address: \_\_\_\_\_

Phone: Home: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

If we need to contact you, which is the preferred number? [ ] Home [ ] Cell [ ] Work

Can we leave a message at this number on the answering machine? [ ] yes [ ] no Are there other members of the household that we may leave the message with regarding your health matters? [ ] yes [ ] no If so whom? \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Preferred Pharmacy (Name & Address): \_\_\_\_\_

Government regulations require we ask for the following identifying information.

Gender: [ ] Male [ ] Female

Race: [ ] Caucasian [ ] African American [ ] Hispanic [ ] Russian [ ] Other: \_\_\_\_\_

Ethnicity: [ ] Non-Hispanic [ ] Hispanic

Primary/Preferred Language: [ ] English [ ] Spanish [ ] Other: \_\_\_\_\_

REFERRING DOCTOR:

Did a doctor send you and do you want us to send the doctor a report about today's visit? [ ] yes [ ] no

Doctor's Name: \_\_\_\_\_ Primary Care Doctor's Name: \_\_\_\_\_

ADULT REVIEW OF SYSTEMS: (Please check boxes to indicate "YES" or "NO".)

Y / N General/Constitutional:

- [ ] Change in Appetite
[ ] Chills
[ ] Fever
[ ] Weight Loss

Y / N Ear, Nose and Throat:

- [ ] Decreased Hearing
[ ] Ringing in Ears
[ ] Dizziness
[ ] Pressure in Ears
[ ] Noise Exposure
[ ] Sore Throat
[ ] Swollen Glands
[ ] Hoarseness / Voice Change
[ ] Difficulty Swallowing
[ ] Nose Bleeds

Y / N Endocrine:

- [ ] Temperature Intolerance
[ ] Excessive Thirst
[ ] Weight Loss

Y / N Respiratory:

- [ ] Cough
[ ] Shortness of Breath (at rest)
[ ] Shortness of Breath (activity)
[ ] Wheezing

Y / N Cardiovascular:

- [ ] Chest Pain (at rest)
[ ] Chest Pain (activity)
[ ] Irregular Heartbeat

Y / N Ophthalmologic (Eyes):

- [ ] Blurred Vision
[ ] Eye Discharge
[ ] Eye Pain

Y / N Gastrointestinal:

- [ ] Abdominal Pain
[ ] Diarrhea
[ ] Nausea
[ ] Vomiting

Y / N Musculoskeletal:

- [ ] Painful Joints
[ ] Weakness in Arms / Legs

Y / N Skin:

- [ ] Dry Skin
[ ] Itching
[ ] Rash

Y / N Neurologic:

- [ ] Headache
[ ] Fainting
[ ] Change in Taste or Smell

**PAST MEDICAL HISTORY:** (Please check boxes to indicate "YES" or "NO".)

Indicate if you have any of the medical problems listed below and add any additional problems not covered in the space provided.

**Y/N**

- High Blood Pressure
- Coronary Artery Disease
- Angina (Chest Pain)
- High Cholesterol
- Asthma
- Emphysema / COPD
- Heartburn / GERD
- Kidney / Renal Disease
- History of Cancer  
Type: \_\_\_\_\_
- Arthritis
- Diabetes
- Thyroid Problems

**Y/N**

- Depression
- Anxiety
- Bleeding Disorder
- History of Clots in Lungs / Legs
- History of TMJ Dysfunction
- History of Migraine Headaches
- Immune Deficiency
- Stroke/CVA
- Autoimmune Disease  
(Rheumatoid, Lupus, Hashimotos, etc.)
- Other: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke?  yes  no  Former smoker, Quit Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If yes, how much? \_\_\_\_\_

Do you drink alcohol?  yes  no

If yes, how much?  1-3 drinks/week  4-10 drinks/week  10+ drinks/week

Do you use recreational drugs (marijuana, cocaine, heroin, etc)?  yes  no

**FAMILY HISTORY:** (Please check boxes to indicate "YES" or "NO".)

**Y/N Do any of these diseases run in your family:**

- Diabetes
- Heart Disease
- Anesthesia Complications

- Cancer
- Bleeding Disorders
- Other: \_\_\_\_\_

**PAST SURGICAL HISTORY:** Please list previous surgeries.

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**CURRENT MEDICATIONS:** Please indicate doses and how often you take.

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
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**ALLERGIES TO MEDICATIONS:**

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