

Ear, Nose, Throat & Plastic Surgery, Inc.

Paul E. Burk, D.O., F.O.C.O.O.
Anthony J. D'Angelo, D.O., F.O.C.O.O.
Richard L. Barnes, D.O., F.O.C.O.O.

Erin Cole, M.S., CCC-A, Clinical Audiologist
Brenda Bear, Practice Administrator

Please answer each question by filling in the appropriate circle fully.

Do you have any medical problems?

- Eye problems
- Vision changes
- Sinusitis
- Allergies in the past
- Ear problems
- Nose problems
- Throat/Neck problems
- High blood pressure
- Mitral valve prolapse
- Heart Attack in the past
- Asthma
- COPD
- Genitourinary problems
- Migraine headaches
- Seizures
- Anxiety/Depression
- Diabetes
- Thyroid problems
- Anemia
- Blood cancer
- Skin cancer
- Breast cancer
- Other, please list: _____
- None

Please List all Medications that you are currently taking: _____

Please List all Allergies to Medications and the reaction you have to them: _____

Please List all Surgeries: _____

Ear, Nose, Throat & Plastic Surgery, Inc.

Paul E. Burk, D.O., F.O.C.O.O.
Anthony J. D'Angelo, D.O., F.O.C.O.O.
Richard L. Barnes, D.O., F.O.C.O.O.

Erin Cole, M.S., CCC-A, Clinical Audiologist
Brenda Bear, Practice Administrator

Please answer each question by filling in the appropriate circle fully.

Does anyone in the family have any medical problems?

Mother	<input type="radio"/> Yes <input type="radio"/> No	If yes, please list: _____
Father	<input type="radio"/> Yes <input type="radio"/> No	If yes, please list: _____
Children	<input type="radio"/> Yes <input type="radio"/> No	If yes, please list: _____
Maternal Grand Mother	<input type="radio"/> Yes <input type="radio"/> No	If yes, please list: _____
Maternal Grand Father	<input type="radio"/> Yes <input type="radio"/> No	If yes, please list: _____
Paternal Grand Mother	<input type="radio"/> Yes <input type="radio"/> No	If yes, please list: _____
Paternal Grand Father	<input type="radio"/> Yes <input type="radio"/> No	If yes, please list: _____

Do you?

Drink Alcohol Yes No
If yes, amount: 1 2 3 4 per day per week per month

Smoke Yes No
If yes, amount: 1 2 3
 packs/day packs/week
For how long? <5 yrs 5-10yrs 10-15 yrs >15 yrs

Use Smokeless Tobacco Yes No
Use Recreational drugs Yes No
Are you around smoke Yes No
Are you Employed Yes No
Please List Occupation: _____

Have you experienced any of the following in the last 6 months?

weight change	<input type="radio"/> Yes <input type="radio"/> No
fever	<input type="radio"/> Yes <input type="radio"/> No
chills	<input type="radio"/> Yes <input type="radio"/> No
fatigue (feeling run down)	<input type="radio"/> Yes <input type="radio"/> No
hearing loss	<input type="radio"/> Yes <input type="radio"/> No
sore throat	<input type="radio"/> Yes <input type="radio"/> No
nose bleeds	<input type="radio"/> Yes <input type="radio"/> No
change in voice	<input type="radio"/> Yes <input type="radio"/> No
ringing in ears	<input type="radio"/> Yes <input type="radio"/> No
dizziness	<input type="radio"/> Yes <input type="radio"/> No
allergies	<input type="radio"/> Yes <input type="radio"/> No

