Thomas S. Kang, MD
R. Jonathan Lara, DO
Ramona Toy, FNP-C
William Kluge, FNP-C
Sarah Lim, FNP-C

SONORAN EAR NOSE THROAT AUDIOLOGY

Amanda Kester, AuD
Beth Benites, AuD
Jamie Landau, AuD
Chris Engelkes, AuD
Stacey Trepanier AuD

MEDICAL HISTORY FORM

FULL NAME: ______________________________

FIRST MIDDLE (optional) LAST

DATE OF BIRTH: ____________________ **TODAY'S DATE:** ____________________

HEIGHT (inches): ____________________ **WEIGHT (lbs):** ____________________

CHIEF COMPLAINT (reason for visit): ______________________________

____

DRUG ALLERGIES: [ ] CHECK IF NONE KNOWN

	DRUG NAME	REACTION	SEVERITY (LEVEL 1-MILD TO 4-SEVERE)
1)			
2)			
3)			
4)			
5)			

MEDICAL DIAGNOSES: (e.g. Hypertension, Asthma, Diabetes, etc.; Why are you taking the medications below?)

1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

MEDICATIONS: [ ] CHECK BOX IF MORE SPACE IS NEEDED, AND USE BACK OF SHEET

	DRUG NAME	DOSAGE	FREQUENCY
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

PAST SURGICAL HISTORY	[ ] CHECK BOX IF MORE SPACE IS NEEDED, AND USE BACK OF SHEET
SURGERY TYPE (e.g. Tonsillectomy)	DATE/LOCATION
1)	
2)	
3)	
4)	
5	
6)	

ANESTHESIA HISTORY: [ ] No Complications [ ] Prior Complication: ______

Family History of Complications: ______

SOCIAL HISTORY

TOBACCO USE: [ ] NEVER [ ] FORMER (Quit date:) [ ] LIGHT USER [ ] HEAVY USER

ALCOHOL USE: [ ] NO [ ] YES (drinks per day: ______) [ ] SOCIAL

DRUG USE: [ ] NO [ ] YES - MARIJUANA [ ] YES - OTHER

CAFFEINE USE: [ ] NO [ ] YES (drinks per day: ______)

OCCUPATION: ______

REVIEW OF SYSTEMS [ ] CHECK IF NONE APPLY

EAR	NOSE	THROAT	RESP
☐ Pain	☐ Drainage	☐ Hoarseness	☐ Cough
☐ Drainage	☐ Congestion	☐ Swallowing Issues	☐ Difficulty Breathing
☐ Hearing Changes	☐ Odor	☐ Sore Throat	☐ Wheezing
☐ Dizziness	☐ Pain	☐ Snoring	☐ Coughing up Blood
☐ Tinnitus / Ringing	☐ Bloody Nose	☐ Dry Mouth	
☐ Pressure	☐ Loss of Smell		

PREFERRED PHARMACY

PHARMACY NAME: ______

PHARMACY ADDRESS OR CROSS STREETS: ______

PHARMACY PHONE NUMBER: ______

PROVIDER INFORMATION

PRIMARY CARE PROVIDER: ______

REFERRING PROVIDER: ______

HOW DID YOU HEAR ABOUT US?: ______

SIGNATURE: ______ DATE: ______

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PATIENT INFORMATION

FULL NAME: ____

FIRST MIDDLE (optional) LAST

DATE OF BIRTH: ____________________ TODAY'S DATE: ____________________

PREFERRED NAME: ____________________

SEX: [ ] Male [ ] Female [ ] N/A [ ] Other: ____________________

HOME ADDRESS: ____

CITY/STATE/ZIP: ____

MOBILE PHONE: ____________________ HOME PHONE: ____________________ WORK PHONE: ____________________

EMAIL ADDRESS: ____

PREFERRED METHOD OF CONTACT: [ ] MOBILE [ ] HOME [ ] WORK [ ] EMAIL [ ] MAIL

DEMOGRAPHICS

PREFERRED LANGUAGE: [ ] English [ ] Spanish [ ] Other (please specify): ____________________

RACE: [ ] White [ ] African American [ ] American Indian/Alaska Native [ ] Asian
[ ] Pacific Islander [ ] Other [ ] Choose Not to Specify

ETHNICITY: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: ____

RELATIONSHIP TO PATIENT: ____________________ PHONE NUMBER: ____________________

ADDRESS: ____

CITY/STATE/ZIP: ____

SIGNATURE: ____ DATE: ____________________