PHILLIP L. KHALIL, D.O.

Adult & Pediatric Ear, Nose & Throat
Otolaryngology – Head & Neck Surgery

New Patient History & Physical
Date: _____

Patient Name: _____ **DOB:** _____ **Age:** _____

Please complete highlighted sections:

Who sent you to see us? _____

Chief Complaint: Describe your major symptoms or reason for your visit today.

_____

_____

Clinician: _____

_____

Histories of Present Illness: Briefly describe the history of the illness that caused you to seek our care.

_____

_____

_____

_____

_____

_____

How long have your symptoms been present?

_____

What makes the symptoms better or worse?

_____

What tests have been performed?

_____

What treatments have you tried so far?

_____

Have you had allergy testing, what were the results?

_____

Clinician: Elements, location, quality, severity, duration timing, context, modifying factors, associated signs/symptoms

_____

_____

_____

_____

_____

_____

Past Medical History: Have you had any of the following health problems? Check all that apply.

- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis (TB)
- ☐ Stroke
- ☐ Seizures
- ☐ Head Injury
- ☐ Migraines
- ☐ Meningitis
- ☐ Anemia
- ☐ Arthritis/Joint Pain
- ☐ Back Problems
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hepatitis
- ☐ Bleeding Disorder
- ☐ Reflux Disease
- ☐ Ulcers
- ☐ Jaundice
- ☐ Kidney Infections
- ☐ AIDS/HIV+
- ☐ Thyroid Problems
- ☐ Sinus Disease
- ☐ Hearing Loss
- ☐ Cystic Fibrosis
- ☐ Cancer, Type:
- ☐ Down's syndrome

Clinician: _____

_____

Current Medications: List all medications you are currently taking.

Medication	Dose	Medication	Dose	Medication	Dose

Allergies to Medications: List all allergies and the kind of reaction.

Medication	Reaction

Preferred Pharmacy: _____ Phone: _____

Past Surgical History: List any surgeries you have had.

Surgery:	Date:	Surgery:	Date:

Social History: Check/answer all that apply

Have you ever smoked? ☐ Yes☐ No Do you smoke now? ☐ Yes ☐ No If yes, ___ packs per day for the last ____ years.
How much alcohol do you drink? ____ drinks per ☐ day ☐ week ☐ month
Who lives with you at home: _____
What is your occupation? _____

Family History: Check all that apply.

☐ Heart Disease	☐ Stroke	☐ Hepatitis	☐ Thyroid Problems
☐High Blood Pressure	☐ Migraines	☐ Hearing Loss	☐ Bleeding Disorder
☐ Tuberculosis (TB)	☐Reflux Disease	☐ AIDS/HIV+	☐ Arthritis/Joint Pain
☐ Asthma	☐ Diabetes	☐ Ulcers	☐ Cancer, Type:

Clinician: _____

Review of Systems: Check all that apply to you.

General
☐ Fever
☐ Weight Loss
☐ Weight gain
☐ Night sweats
☐ Loss of appetite

Eyes
☐ Blurry vision
☐ Double vision
☐ Change in vision
☐ Eye pain
☐ Excess tearing

Ears
☐ Hearing loss
☐ Ringing of ears
☐ Ear pain
☐ Ear drainage
☐ Ear fullness
☐ Dizziness

Nose
☐ Obstruction/congestion
☐ Postnasal drip
☐ Drainage/pus
☐ Loss of smell

Throat
☐ Recent voice change
☐ Difficulty breathing
☐ Difficulty swallowing
☐ Can't clear throat
☐ Chronic cough
☐ Hoarseness
☐ Sore throat
☐ Loss of taste

Pulmonary
☐ Wheezing
☐ Coughing
☐ Coughing up blood
☐ Pain with breathing

Cardiovascular
☐ Chest Pain
☐ Short of breath
☐ Swollen ankles/legs
☐ Dizziness/fainting
☐ Palpitations

Gastrointestinal
☐ Nausea/vomiting
☐ Vomiting blood
☐ Heartburn
☐ Abdominal pain
☐ Constipation
☐ Blood in stool
☐ Diarrhea

Genitourinary
☐ Painful urination
☐ Frequent urination
☐ Blood in urine

Neurologic/Psych
☐ Numbness
☐ Weakness
☐ Tingling
☐ Convulsions
☐ Blackouts
☐ Sensory disturbances
☐ Motor disturbances
☐ Depression
☐ Memory difficulties

Hematology
☐ Anemia
☐ Bleeding tendency
☐ Prior transfusion

Endocrine
☐ Heat intolerance
☐ Cold intolerance
☐ Increased water intake

Skin/musculoskeletal
☐ Skin lesions/rashes
☐ Pigmentation changes
☐ Joint pain/limited motion
☐ Muscle weakness
☐ Back pain

Allergy
☐ Inhalant allergy
☐ Contact allergy
☐ Environmental allergy
☐ Food allergy
☐ Latex allergy

Other: _____