CENTRAL COLORADO EAR, NOSE AND THROAT
920 RUSH DRIVE
SALIDA, CO 81201
Telephone: 719-539-9300 Fax: 719-539-9333

Name:_____Age:_____DOB:_____Date:_____
Reason for today's appointment:_____
Referring Physician:_____Primary Physician:_____

Check any symptoms that have been bothersome in the past year:

___Earaches ___Loud snoring/apnea ___Hoarseness
___Ear drainage ___Nasal blockage ___Difficulty swallowing
___Hearing loss ___Loss of smell or taste ___Enlarged glands
___Ringing/noise in ears ___Seasonal allergies ___Chronic cough
___Dizziness ___Post nasal drip ___Indigestion/Hrtburn
___Double vision ___Sinusitis ___Weight loss
___Noise Exposure ___Nose bleeds ___Shortness of breath
___Skin lesion/mole which has changed color/size ___ Chest pain/palpitations
___Severe headaches ___Abdominal pain ___Constipation/diarrhea
___History of radiation therapy ___Bone pain ___Muscle pain
___History of easy bleeding/bruising ___History of seizures ___Depression
___History of measles/mumps ___History of pneumonia ___Rheumatic fever

Past Medical History:

___Cancer (type_____) ___Thyroid problems ___Asthma/Emphysema
___Heart disease ___Sleep apnea ___Arthritis
___Heart murmur ___Stroke or mini stroke ___Hepatitis/Jaundice
___High blood pressure ___Tuberculosis ___HIV/AIDS
___Diabetes ___High cholesterol ___Reflux
Other medical problems:_____
For Children, are immunizations up to date?_____yes _____no

Previous Surgeries:_____
_____
_____

Social History:_____

___Currently smoke_____packs per day _____Drink alcohol
___Past smoker _____Use drugs
Occupation_____ _____Travel outside country

Family History:_____

___Heart disease ___Bleeding tendencies ___Thyroid Disease
___Diabetes ___High blood pressure ___Hearing loss
___Cancer (type:_____) ___TB/HIV/AIDS Other:_____

Medications you are currently taking: Allergies:

_____ _____ _____
_____ _____ _____
_____ _____ _____