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EAR NOSE & THROAT

Jeremy P. Watkins, MD
J. Brad McIntyre, MD
Sean M. Callahan, MD

5751 Edwards Ranch Rd | Fort Worth, TX 76109
Phone: 817.332.8848 | Fax: 817.335.2670

PATIENT MEDICAL INFORMATION

Name: _____ Date: _____

Sex: M / F Age: _____ Date of Birth: _____ Height: _____ Weight: _____

FOR OFFICE USE ONLY: Temperature: Vitals:

PCP:_____

List any allergies to medications and/or food: _____

Briefly describe your present problem and how long it has caused you problems: _____

Prior Medical History:

____ Heart Attack/Heart Disease
____ Congestive Heart Failure
____ Hypertension
____ COPD/Lung Disease
____ Stroke
____ HIV/AIDS
____ Seizures
____ Diabetes
____ Sleep Apnea
____ Asthma
____ Arthritis
____ Glaucoma / Cataracts
____ Tuberculosis
____ Cancer (Specify Type) _____
____ Liver/Kidney Disease (Specify Type) _____
____ Spine Disorders (Specify Type) _____
____ Thyroid Disorders (Specify Type) _____
____ Bleeding/Clotting Disorders (Specify Type) _____

Please check if any of the following complaints apply:

Constitutional: ____ Weight Loss ____ Fever
Eyes: ____ Vision Change
Respiratory: ____ Wheezing ____ Shortness of Breath
Cardiovascular: ____ Chest Pain ____ Palpitations
Gastrointestinal: ____ Heartburn ____ Nausea
Genitourinary: ____ Painful Urination ____ Blood in Urine
Musculoskeletal: ____ Joint Pain
Skin: ____ Lesions on Skin
Neurological: ____ Numbness ____ Weakness ____ Seizures
Psychiatric: ____ Depression ____ Anxiety ____ Sleep Disorder
Endocrine: ____ Temperature Intolerance
Hemotologic/Lymphnodes ____ Blood Clotting Disorder
Allergic/Immunologic ____ Sneezing ____ Eye Irritation

Problems not listed above? _____
Do you drink alcohol? _____ How much daily? _____
Caffeinated beverages? _____ How much daily? _____
Do you smoke? _____ How much? _____ Quit? _____ When? _____

Preferred Pharmacy: _____ Location & Phone#: _____
Current Medications: _____

List all prior surgeries with the year they were performed: _____

Any anesthesia-related problems? _____ If so, what type? _____

Please list which *immediate* family members have the following:
Family History: Cancer _____ Diabetes _____ High Blood Pressure _____ Heart Disease _____
Problems not listed? _____

Birth History: *(for patients under the age of 18)*
Was the child born on time? _____ Problems during mothers pregnancy? _____
Breathing problems at birth? _____ Immunizations current? _____
History of: Asthma _____ Reflux _____ Seizures _____