BEACH EAR NOSE & THROAT
WILLIAM S. TEACHEY, MD
Comprehensive personal care for your entire family.

(757) 464-9165
Fax (757) 464-4478
www.beachent.com

PATIENT INFORMATION

PATIENT NAME _____ **DATE** _____

Medicine Allergies: NKMA _____ : _____

Referring Physician _____ Patient Age _____

Chief Complaint: (Briefly explain the major reason you are seeing Dr. Teachey today) _____

_____

_____

History of Present Illness (HPI)

Location (site of chief complaint) _____ N/A

Quality of chief complaint (eg, sharp or dull pain) _____ N/A

Severity of chief complaint (mild, moderate, extreme) _____ N/A

Duration (how long have you been aware of this problem; e.g., for 3 months) _____

Timing (eg, worse in spring, during exercise, at night) _____ N/A

Context (eg, worsening, recurrent, chronic) _____ N/A

Modifying factors

(Can you identify anything which makes the symptom(s) worse/better?) ☐ Yes ☐ No _____ N/A

_____

Associated Signs and Symptoms (eg, discolored drainage, pain, fever) _____

What treatment has been given for this problem thus far? Did it help? _____

_____

_____

Additional Information _____

_____

_____

FOR OFFICE USE ONLY

Return Visit: ROS, PFSH reviewed: ☐ Yes ☐ No

Changes: ☐ Yes ☐ No _____

I hereby attest that I have reviewed the information contained herein _____

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Review or Systems

Have you ever had problems or diseases in the areas below? If yes, please explain.

Please check appropriate response ❑ Yes ❑ No

☆**Eyes**	❑ Yes ❑ No	_____
Glaucoma	❑ Yes ❑ No	_____
Blurring of vision	❑ Yes ❑ No	_____
Double vision	❑ Yes ❑ No	_____
☆**Ears**	❑ Yes ❑ No	_____
☆**Nose, Sinuses**	❑ Yes ❑ No	_____
Sinus infections, sinus pressure, nasal blockage, nasal allergies		
☆**Mouth, Throat**	❑ Yes ❑ No	_____
Hoarseness, sore throats	❑ Yes ❑ No	_____
Problems swallowing	❑ Yes ❑ No	_____
☆**Cardiovascular**	❑ Yes ❑ No	_____
Irregular heart beat	❑ Yes ❑ No	_____
Circulation, ankle swelling	❑ Yes ❑ No	_____
High blood pressure	❑ Yes ❑ No	_____
Angina, chest pain	❑ Yes ❑ No	_____
Do you have a pacemaker?	❑ Yes ❑ No	_____
☆**Respiratory**	❑ Yes ❑ No	_____
Asthma, wheezing	❑ Yes ❑ No	_____
Emphysema	❑ Yes ❑ No	_____
Chronic cough	❑ Yes ❑ No	_____
Shortness of breath	❑ Yes ❑ No	_____
☆**Gastrointestinal**	❑ Yes ❑ No	_____
Acid stomach Problems	❑ Yes ❑ No	_____
Hiatal Hernia	❑ Yes ❑ No	_____
Reflux, heartburn	❑ Yes ❑ No	_____
Stomach ulcer	❑ Yes ❑ No	_____
Hepatitis	❑ Yes ❑ No	_____
☆**Genitourinary**	❑ Yes ❑ No	_____
Prostate, bladder, or kidney problems; venereal disease; difficulty urinating; frequency		
☆**Musculoskeletal**	❑ Yes ❑ No	_____
Arthritis, joint pain		
☆**Integumentary** (skin)	❑ Yes ❑ No	_____
Rashes, lesions		
☆**Neurological**	❑ Yes ❑ No	_____
Paralysis or weakness of any part of the body; seizures; stroke; choking on food		
☆**Psychiatric**	❑ Yes ❑ No	_____
Mental disorders, psychiatric treatment		
☆**Endocrine**	❑ Yes ❑ No	_____
Diabetes	❑ Yes ❑ No	_____
Do you use insulin?	❑ Yes ❑ No	_____
Thyroid problems, frequent thirst or urination	❑ Yes ❑ No	_____

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☆**Hematologic/Lymphatic**	❑ Yes ❑ No	_____
Anemia	❑ Yes ❑ No	_____
Blood clotting disorders	❑ Yes ❑ No	_____
Easy bruising	❑ Yes ❑ No	_____
Lymphoma or leukemia	❑ Yes ❑ No	_____
☆**Allergic Immunologic**	❑ Yes ❑ No	_____

Excess sneezing, hives, sensitivity to pollens, chemicals, or foods

☆**Constitutional symptoms-** Have you recently had significant weight gain or loss, or fever?	❑ Yes ❑ No	_____
☆**Have you ever had Cancer?..**	❑ Yes ❑ No	_____
☆**Other areas or diseases not mentioned io this review...**	❑ Yes ❑ No	_____

PERSONAL FAMILY AND/OR SOCIAL HISTORY

PERSONAL HISTORY

Operations (list) Year

_____ _____
_____ _____
_____ _____

Serious Illness or Injuries Requiring Hospitalization (list) Year

_____ _____
_____ _____

Medications- (check here____ if there is an attached list) - otherwise, please list:

_____

Allergies to medication

Penicillin allergy ❑ Yes ❑ No List **other medication allergies** _____

Smoking

Do you smoke (or use tobacco otherwise)? ❑ Yes ❑ No _____
Did you smoke in the past? ❑ Yes ❑ No _____
If you have quit smoking, when did you quit? _____
How many packs do you/did you smoke per day? _____

Alcohol intake

Do you consume alcohol? ❑ Yes ❑ No _____
Did you consume alcohol in the past? ❑ Yes ❑ No _____
How much do you/did you consume per week? ❑ Yes ❑ No _____
Occupation (if retired, occupation prior to retirement) _____

Family History Relationship of family member to you

Is there any family history of tuberculosis? ❑ Yes ❑ No _____
Does/did anyone who is/was a blood relative of yours have:
- A bleeding disorder ❑ Yes ❑ No _____
- Diabetes ❑ Yes ❑ No _____
- Heart or blood vessel disease ❑ Yes ❑ No _____
- Other familial or inherited diseases or diseases which tend to run in your family ❑ Yes ❑ No _____
- Other ❑ Yes ❑ No _____

Patient or guardian signature _____

(When information up to this point written by patient or guardian)

History taken from: ❑ Patient ❑ Spouse ❑ Guardian ❑ Accompanying medical records ❑ Other _____
Historian: ❑ Patient ❑ Dr. Teachey ❑ Staff ❑ Other _____

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William S. Teachey, M.D.