Shasta ent Specialists
Redding sinus Center

George H. Domb, MD
2125 Court Street
Redding, CA 96001
Phone: 530-242-5600
Fax: 530-242-5605

MEDICAL INFORMATION FORM

PLEASE COMPLETE: **Today's Date: _____**

Patient's Name: _____ **Gender:** ☐ Male ☐ Female

Date of Birth: _____ **Family Doctor: _____** **Referred by: _____**

Reason for your visit: _____

Have you had a Sinus/Head CT / MRI or X-Ray done? YES NO **Location:** MD Imaging Advanced Imaging Other:

PLEASE CHECK ANY CURRENT SYMPTOMS

1. EARS:

- _____ **Itchy**
- _____ **Pain**
- _____ **Drainage**
- _____ **Hearing Loss**
- _____ **Ringing**
- _____ **Dizziness**

2. NOSE & SINUS:

- _____ **Runny Nose**
- _____ **Post-Nasal Drip**
- _____ **Stuffy or Congested**
- _____ **Nosebleeds**
- _____ **Problems with Sense of Smell**
- _____ **Polyps**

3. MOUTH & THROAT:

- _____ **Sore Throat**
- _____ **Tonsillitis**
- _____ **Mouth Breathing**
- _____ **Problems Swallowing**
- _____ **Hoarseness**

4. SNORING:

- _____ **YES**
- _____ **NO**
- _____ **DAYTIME SLEEPINESS**

5. TABACCO USE: **circle: YES / NO**

IF YES: **YEAR STARTED: _____** **QUIT: YES / NO** **WHEN: _____**

CHEW: YES / NO **CIGARETTES: YES / NO** **PACKS/DAY: _____**

PIPE: YES / NO **CIGAR: YES / NO**

6. ALCOHOL USE: **circle: YES / NO**

NEVER: _____ **DAILY: _____** **WEEKLY: _____** **SOCIAL: _____**

QUIT: YES / NO **WHEN: _____**

Reviewed by Employee: _____

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7. ALLERGIES TO MEDICATIONS:

_____

_____

8. MEDICATIONS YOU ARE CURRENTLY TAKING; PLEASE INCLUDE OVER THE COUNTER:

_____

_____

9. EARS, NOSE OR THROAT MEDS YOU HAVE TAKEN IN PAST, AND WHY? INCLUDING OVER THE COUNTER.

_____

_____

10. DO YOU TAKE BLOOD THINNERS? Circle: YES / NO

circle: PLAVIX ASPIRIN IBUPROFEN PERSANTINE COUMADIN

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

_____ **Diabetes**	_____ **High Blood Pressure**
_____ **Hepatitis**	_____ **Asthma / Lung Problems**
_____ **Bleeding Tendency**	_____ **Chest Pain**
_____ **AIDS / HIV+**	_____ **Heart Attack / Date: _____**
_____ **Prev. Ear Surgery**	_____ **Stroke**
_____ **Nose / Sinus Surgery**	_____ **Loud Noise Exposure**

11. Please List Prior Surgeries, including Month & Year:

_____

_____

12. Ladies: Could you be Pregnant? YES / NO

WOULD YOU LIKE DR. DOMB TO KNOW ANYTHING ELSE ABOUT YOU? _____

_____

_____

Reviewed by Employee: _____