



ENT Specialists, P.A.

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Hearing Care Center

Tricia Pastore, Au.D.

Patient Name _____	Today's Date _____
Current Pharmacy _____	Referred By _____
Patient/Guarantor Email _____	Family M.D. _____
Age _____ Height _____ Weight _____ Gender _____	Single/Married/Widowed _____
Current Employment (where) _____	Job Title _____

Reason for Visit: _____

Date of Onset: _____

Medications Tried: _____

Recent Diagnostics: Hearing Test _____ CT/MRI _____

Blood Work _____ (where performed) _____

Family History: NONE

Adopted _____ Allergy _____ Hearing Loss _____ Bleeding Disorder _____

Anesthesia Complication _____ Other _____ (if "other" Be Specific)

Patient's Medical History: NONE

Asthma _____ Apnea _____ Reflux _____ Cancer _____

Anxiety _____ Depression _____ Migraines _____ Thyroid _____

Diabetes _____ Bleeding _____ High Blood Pressure _____

Heart Attack/Stroke _____ Anesthesia Complications _____

Other (Be Specific) _____

Any Implants?(where) _____ Date Implant Placed _____

Past Surgeries: NONE

Tonsillectomy _____ Adenoidectomy _____ Cancer: _____

Wisdom Teeth _____ Orthopedic _____ Cardiac: _____

Nasal/Sinus _____ GYN: _____

Gallbladder _____ Hernia _____ Thyroid _____ Appendix _____

Other (Be Specific) _____

Tobacco Use: NONE

Cigarettes: Smokes _____ Packs/Day for _____ Years

Former Smoker: Quit _____ years ago Chews Tobacco _____

Alcohol Use: NONE

Social _____ Heavy _____ Type: _____

Current Problems: _____

All Negative Except _____

Shortness of Breath _____ Difficulty Swallowing _____ Chest Pain _____

Neck Mass _____ Anemia/Bruising _____ Rash _____ Joint Pain _____

Persistent Headaches _____ Sleep Problems _____ Visual Problems _____

Dizziness _____ Snoring _____ Other _____

M.D. ONLY

FILL OUT COMPLETELY

ADULT NEW