EASTERN VIRGINIA
EAR, NOSE & THROAT
SPECIALISTS

MRN#: _____

Today's Visit

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Primary Care Physician: _____

Height: _____ Weight: _____

What specific ear, nose or throat concerns would you like to address today?

_____

_____

Review of Systems

Please **CHECK** if you are **CURRENTLY** having any of these symptoms

☐	Fever	☐	Dizziness
☐	Seasonal Allergies	☐	Thyroid problems
☐	Eye redness	☐	Abnormal bleeding
☐	Snoring	☐	Pregnant
☐	High blood pressure	☐	Under Pain Management
☐	Indigestion/GERD	☐	Cannot have MRI (implantable device)
☐	Joint pain	☐	Sinusitis
☐	Hearing Loss	☐	Tinnitis

Do you have an Advanced Care Plan or Living Will? **YES** **NO**

FOR MD USE ONLY

Day Month Year

_____ Allergy Inhalant Testing _____ Audio/Tymp Follow Up ENT: _____

_____ Total IgE _____ Labs Follow Up Allergy: _____

_____ Foods (IgE/IgG) _____ VNG/ABR Follow Up Audiology: _____

Consult/Referrals: _____ Follow Up Audio/ENT: _____

_____ q 2 Weeks _____ q 3 Weeks _____ q 4 Weeks _____ q 5 Weeks _____ q 6 Weeks _____ q

☐ U/S Neck Thyroid ☐ CT Sinus Neck T-Bone ☐ MRI IAC's Neck Head ☐ Radiology: _____