Cleveland Ear Nose Throat, Inc.
Dr. Bert M. Brown

Date: _____

Name: _____ **DOB:** _____

Family Physician: _____

Who sent you here? _____

Pharmacy: _____ Phone: _____

Street: _____ City: _____

Why are you here today: (Please be specific, i.e., right or left side, upper or lower, front or back, etc. and for how long)

_____

_____

_____

Height: _____

Weight: _____

Medication Allergies: _____

_____

Medical History: _____

_____

_____

Surgical History: _____

_____

_____

Current Medications: _____

_____

_____

Social History: **Smoker?** Current ☐ Former ☐ Never ☐

Alcohol Consumption? No ☐ Yes ☐

How many drinks per week? _____

Family History: