INTAKE FORM - TONSILS

Name: _____ DOB (dd/mm/yyyy): _____

What tonsil issues prompted your referral to Dr. Mabini? (please circle):

Recurrent infections (colds, strep throat) Tonsil stones Enlarged tonsils Snoring

Other: _____

Do you have, or have you had any of the following symptoms? (please check if yes):

- ☐ Recurrent throat infections
- ☐ Frequent sore throat
- ☐ Fevers
- ☐ Fatigue
- ☐ Swollen/sore lymph nodes
- ☐ Snoring
- ☐ Voice hoarseness
- ☐ Sleep apnea
- ☐ Difficulty concentrating
- ☐ Ear infections
- ☐ Trouble swallowing
- ☐ Trouble breathing

Have you had recurrent throat infections, such as colds or strep throat? _____

If you have had strep throat, please state how many episodes over what duration of time (e.g. three infections in the last year and a half): _____

Have you swabbed positive for strep throat? Was it every time?:

_____

Have you ever been swabbed AFTER completing a course of antibiotics, to make sure that the infection cleared?: _____

How many times have you been treated with antibiotics, and which antibiotics did you receive?:

_____

Have you ever had a sleep study? If yes, when? What were the results?:

_____