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Patient Information

- ***All fields required**

First: _____ Middle: _____ Last: _____

If Minor Patient, Parent's Name: _____

Date of Birth: _____ Gender: M F Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Other: _____ Cell or Work

Email: _____ May we email you promotional information? Yes No

Marital Status (circle): Single Married Other Minor

Occupation: _____

Ethnicity: _____ Race: _____ Preferred Language: _____

Referring Physician: _____

Primary Care Physician: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Release of Information: (*required) Who may we talk to about your account? List any party other than your Physician who would be authorized to receive information regarding your account. If none, please print Patient Only.

I authorize: _____Relationship:_____ Initials:_____

How did you hear about us? Website Newspaper Phonebook Friend Physician

Responsible Party Information (if other than patient)

Name: _____ Relationship to Patient: _____

DOB: _____ SS#: _____ Employer: _____

PAST MEDICAL HISTORY

Name:_____ **Patient**

_____ **Date of Birth:**

Have you been treated for:

	NO	YES		NO	YES
No Past Medical History	□	□	Anemia	□	□
Eye Disease/Glaucoma	□	□	Bleeding Problems	□	□
Hearing Problems	□	□	Allergy	□	□
Sinus Problems	□	□	Stroke	□	□
Thyroid Disorder	□	□	Seizures/Convulsions	□	□
Lung Problems	□	□	Depression	□	□
Tuberculosis (TB)	□	□	Cancer	□	□
Heart Disease	□	□	Diabetes	□	□
Palpitations	□	□	Alcohol Problem	□	□
High Blood Pressure	□	□	AIDS/HIV	□	□
Stomach Problems	□	□	Blood Clots	□	□
Ulcers	□	□	Anesthesia Problems	□	□
High Cholesterol	□	□	Arthritis	□	□
			Other	□	□

List Any Past Surgeries or Hospitalizations:

1. _____ 3. _____
2. _____ 4.. _____

Family Medical History:

	NO	YES	Relative		NO	YES	Relative
Patient Denies Any Contributing Family History				Heart Disease			
Allergies				High Blood Pressure			
Anesthesia Problems				Kidney Disease			
Bleeding Problems				Lung Disease			
Cancer				Thyroid Disease			
Diabetes							

Social History:

Tobacco Smoking: Y N Quit: _____ Alcohol: Drinks per Week: _____

Tobacco Chewing: Y N Quit: _____ Exercise Program: Y N

Second Hand Smoke Exposure: Y N Daily Aspirin Use: Y N

Height: _____ Weight: _____

Current Review of Systems

Patient Name: _____
Date of Birth: _____

Medication Allergies:

_____

_____

Current Medications:

_____

_____

Current Review of Systems:

Please check the appropriate boxes for symptoms you are currently experiencing.

	NO	YES		NO	YES
Allergy			**Respiratory**		
Sneezing	□	□	Cough	□	□
Post Nasal Drip	□	□	Wheezing	□	□
Watery/Itchy Eyes	□	□	Coughing up Blood	□	□
			Shortness of Breath	□	□
Eyes			**Endocrine**		
Change in Vision	□	□	Feel Warmer/Colder than others	□	□
			Thirsty Often	□	□
			Hot Flashes	□	□
ENT			**Hematologic**		
Hearing Loss	□	□	Bleeding Problems	□	□
Lightheadedness	□	□	**Cardiac**		
Dizziness	□	□	Leg/Feet Swelling	□	□
Nasal Congestion	□	□	Heartbeat Skipping	□	□
Loss of Smell	□	□	**Musculoskeletal**		
Hoarseness	□	□	Joint Aches	□	□
Throat Clearing	□	□	**Kidney/GU**	□	□
Sinus Pressure	□	□	Bloating/Edema		
Snoring/Apnea	□	□	**Skin**	□	□
Dryness of Throat	□	□	Concerning Growths		
Lump in Throat	□	□			
Nasal Drainage	□	□			
GI			**Psychiatric**		
Heartburn/Indigestion	□	□	Depression	□	□
Difficulty Swallowing	□	□			
General			**Neuro**		
Weight Loss/Gain	□	□	Headache	□	□
Fatigue	□	□	Difficulty Sleeping	□	□

Please check if you are interested in receiving information about any of the following:
□ Cosmetic or surgical procedures (i.e. eyelid lift, Botox, Resylane, etc.)
□ Snoring procedures

Patient Signature: _____Date: _____