New Patient Information Form

Name : Birth Date : / /

1. Medical History

DO YOU HAVE OR HAVE YOU EVER HAD (please check box)

☐ **No Known Medical Conditions**
☐ Anesthesia Problems (specify ________________________)
☐ Bleeding Disorder (specify ___________________________)
☐ Hearing Loss
☐ Ear Infections
☐ Ruptured Ear Drum
☐ Sinusitis
☐ Facial Trauma
☐ Tonsillitis (chronic)
☐ Heart Disease
☐ Hypertension
☐ High Cholesterol
☐ Arrhythmia
☐ Other Cardiac Disorder (specify________________________)
☐ Asthma
☐ Sleep / Snoring Problems (specify______________________)
☐ Other Lung Disease (specify ________________________)
☐ Stomach Ulcers / Colitis
☐ GERD (Reflux)
☐ Other Stomach Disorder (specify______________________)
☐Acute Renal Failure
☐ Kidney Stones
☐ Other Renal Disease (specify__________________________)
☐ Musculoskeletal Disorder (specify______________________)
☐ Diabetes (specify_________________ controlled ?_______)
☐ Osteoarthritis
☐ Osteoporosis
☐ Thyroid Disease (specify____________________________)
☐ Other Endocrine Disorder (specify ____________________)
☐ Headache /Migraine
☐ Seizures (specify_____________________________________)
☐ Stroke/TIAs (specify__________________________________)
☐ Other Neurologic Disorder (specify ___________________)
☐ Anemia (Iron Deficiency, Hemolytic or Pernicious)
☐ Environmental Allergies
☐ Chicken Pox
☐ Immune Deficiency
☐ Other Allergy (specify________________________________)
☐ History of Cancer: Type: _____________________________
Diagnosed:___________ Treatment:______________
☐ Psychiatric Disorder (specify__________________________)
☐ Do you have any other disease or condition that you think the doctor should know about?___________________________
____

☐

For Women Only
☐ Are you pregnant, or is there any chance that you might be pregnant?
☐ Are you nursing?

2. Specialists

List any other doctors that you see: ________________________
____
____
____
____

3. Surgical History

☐ **No Surgical History**
☐ Ear Tubes: when______ ☐ Septoplasty: when______
☐ Tonsils: when_____ ☐ Sinus Surgery: when______
☐ Adenoids: when_____
☐ Thyroid (partial, total): when______
☐ Cardiac Stent: when________
☐ Coronary Artery Bypass: x ______, when _______
☐ Joint Replacement: (specify ____________): when________

Please list any additional operations (and dates) that you have had. ____
____
____

4. Family History

☐ **No Known Medical Conditions**
☐ Anesthesia Problems (specify ________________________)
☐ Bleeding Disorder (specify ___________________________)
☐ Hearing Loss: Relationship:_________________
☐ Sinusitis
☐ Heart Disease
☐ Hypertension
☐ High Cholesterol
☐ Other Cardiac Disorder (specify________________________)
☐ Asthma
☐ Other Lung Disease (specify ________________________)
☐ GERD (Reflux)
☐ Other Stomach Disorder (specify______________________)
☐ Renal Failure
☐ Other Renal Disease (specify__________________________)
☐ Rheumatoid Arthritis
☐ Lupus
☐ Musculoskeletal Disorder (specify______________________)
☐ Thyroid Disease (specify____________________________)
☐ Other Endocrine Disorder (specify ____________________)
☐ Headache /Migraine
☐ Seizures (specify_____________________________________)
☐ Stroke/TIAs (specify__________________________________)
☐ Vertigo
☐ Other Neurologic Disorder (specify ____________________)
☐ Allergy/Immune/Skin (specify _________________________)
☐ Cancer : Type:_________ Relationship:_________________
Type:_________ Relationship:________________
☐ Psychiatric Disorder (specify__________________________)
☐

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NEW PATIENT INFORMATION FORM

5. Social History - Adult

Occupation: ☐ Employed ________________(Job Title)
☐ Unemployed ☐ Student ☐ Retired
Marital Status: ☐ Single ☐ Married ☐ Partnered
☐ Divorced ☐ Widowed
Number of Children: 1 2 3 4 5 ____________
Caffeine: ________Drinks/Day
Pets: ____
Nursing Home Resident? Yes No
Name of Facility:______________

Tobacco: ☐ Never ☐ Current ☐ Past
Quit Date: _______ Years as a Smoker_____
Packs Per Day _______

Alcohol: ☐ None ☐ Rare ☐ Social ☐ Regular
Drinks/Week:_________

Illicit Drugs: ☐ Yes ☐ No
List: _________________________________

6. Prior Testing

☐ Allergy Testing: Skin or Blood Test? When____________
Sensitivities: ________________________________
Immuno Therapy: When:______ Duration:_______
☐ CT Scan of the Sinuses or Neck
When_______ Where_________
☐ MRI of the Brain or Neck When_______ Where_________
☐ Swallow Study When_______ Where_________
☐ Ultrasound of the Neck When_______ Where_________

7. Immunizations & Vaccines

Have you received a flu immunization for this season (Oct-Mar)
☐ Yes When__________ ☐ No

Patients 65 years of age or greater:
Have you ever received a pneumonia vaccine?
☐ Yes When__________ ☐ No

8. Current Symptoms

What is your main symptom? ___________________________
When did this symptom start?___________________________
How Frequent?___________ Rate the Severity (1-10)________
Quality (eg. pain, pressure, shooting)_____________________
____

____

____

9. Review of Systems

DO YOU HAVE OR HAVE YOU EVER HAD (please check box)

Ear
☐ Ear Pain R - L - Both
☐ Hearing Loss R - L - Both
☐ Ear Drainage R - L - Both
☐ Noises in Ear R - L - Both

Nose
☐ Nasal Obstruction
☐ Sinus Pressure or Pain
☐ Abnormal Sense of Smell
☐ Runny Nose

Throat
☐ Sore Throat
☐ Hoarseness
☐ Snoring/Sleep Apnea
☐ Throat Clearing
☐ Swallowing Problems

Eyes
☐ Eye Pain
☐ Itching or Watery Eyes

Heart / Chest
☐ Chest Pain
☐ Dizziness
☐ Palpitations

Lungs / Respiratory
☐ Cough
☐ Shortness of Breath
☐ Coughing up Blood
☐ Wheezing

Stomach / Gastrointestinal
☐ Heartburn / Reflux
☐ Stomach Pain

Urinary
☐ Painful Urination
☐ Frequent Urination

Musculoskeletal
☐ Joint Pain/Aches
☐ Muscle Pain/Aches

Skin
☐ Itching
☐ Rash
☐ Hives

Neurology
☐ Headaches
☐ Fainting

Blood / Glands
☐ Easy Bruising
☐ Bleeding Problems
☐ Swollen Glands

Endocrine
☐ Heat / Cold Intolerance
☐ Sweating at Night

Psychiatric
☐ Anxiety or Panic
☐ Depression

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NAME : BIRTH DATE : / /

Medication List

Please include supplements and over-the-counter medications

Medication:	Dose:	Frequency:

Medication Allergies

Please list the name of the medication, prescription or over-the-counter, and your reaction (Rash, vomiting, difficulty breathing ,etc.)

Medication:	Reaction:
Example: Penicillin	*Rash*

Pharmacy:____________________

Name:________________________

Address/Location:_______________

____

Phone:________________________

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