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? ☐Yes ☐ No

Are you nursing? ☐Yes ☐ No

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 _____, 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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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: _____
Immunotherapy: 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. Current Symptoms

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

8. Review of Systems

PLEASE NOTE ANY CURRENT SYMPTOMS BELOW
(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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Medication List

Please include supplements and over-the-counter medications

Medication:	**Dose:**	**Frequency:**

Medication Allergies

Medication:	**Reaction:***(Rash, vomiting, difficulty breathing ,etc.)*

Pharmacy:

Name:_____

Address/Location:_____

_____

Phone:_____

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