Patient Intake Form for Allegany Ear, Nose, & Throat

Patient Name:_____

What brings you to the office today?

_____
_____
_____

Who is your primary care doctor? _____

Please list your current medications:

_____
_____
_____
_____
_____

Are you allergic to any medications? If so, please list and describe your reaction.

_____
_____
_____
_____
_____

Non-medication allergies (please describe reaction):

_____
_____
_____

Have you been tested for allergies? If so, when and what were the positive findings?

_____

Have you received shots for allergies in the past? If so, when and for what?

_____

Which pharmacy do you prefer to use?_____

Past Health History:

(Circle if diagnosed with particular disease)

Cancer of:
Bone
Breast
Lung
Prostate
Throat
Other_____

Nose/Throat
Chronic Sinusitis
Nasal allergies
Tonsillitis
Sleep Apnea
TMJ
Other_____

Lungs
Asthma
Bronchitis
Emphysema
Tuberculosis
Other_____

Genitourinary
Renal Failure
Renal Insufficiency
Stress Incontinence
Other_____

Brain
Alzheimer's
Epilepsy
Multiple Sclerosis
Parkinson's
Stroke
Other_____

Glandular Disorders
Diabetes type I
Diabetes type II
Thyroid excess
Thyroid nodule
Low thyroid hormone
Other_____

Head/Face/Eyes/Ears
Headaches
Glaucoma
Macular degeneration
Frequent ear infections
Meniere's Disease

Cardiac
Congestive Heart Failure
Heart disease
Previous heart attack
High blood pressure
Irregular heart beat
Mitral valve prolapse
Valves or Stents
Other_____

Abdominal Disorders
Gallstones
Cirrhosis
Diverticulitis
GERD
Hepatitis
Other_____

Bones
Gout
Rheumatoid Arthritis
Osteoporosis
Slipped disk in neck
Other_____

Mental Health
Alcohol dependency
Drug dependency
Depression
Other_____

Immunologic Disorders
AIDS
HIV
Lupus

Surgical/Hospital History

Have you ever had problems with anesthesia? If so, what type of problem?

_____

List any past surgeries, with dates: None (circle if correct)

_____
_____
_____
_____
_____

List hospitalizations for non-surgical reasons, with dates: None (circle if correct)

_____
_____
_____
_____

List any previous serious injuries: None (circle if correct)

_____
_____
_____
_____

Are your immunizations up to date? (circle appropriate response)

Yes No

Have you had any recent studies (labs, x-rays, MRI, CT scans etc.)?
Please include location and dates:

_____
_____
_____

Are you pregnant? (Circle appropriate response)

Yes No

Family History

Do you have a family history of any of the following? Please list relation(s).

Cancer of the throat - No (circle if appropriate)_____

Cancer of the lung - No (circle if appropriate)_____

Cancer of the thyroid - No (circle if appropriate)_____

Cancer of the breast - No (circle if appropriate)_____

Growth or development problems - No (circle if appropriate)_____

Heart Disease - No (circle if appropriate)_____

High Blood Pressure - No (circle if appropriate)_____

Asthma - No (circle if appropriate)_____

Cystic Fibrosis - No (circle if appropriate)_____

Cirrhosis of the Liver - No (circle if appropriate)_____

Colitis - No (circle if appropriate)_____

Kidney Disease - No (circle if appropriate)_____

Stroke - No (circle if appropriate)_____

Diabetes - No (circle if appropriate)_____

Thyroid Disease - No (circle if appropriate)_____

Anemia - No (circle if appropriate)_____

Bleeding/Clotting Disorders - No (circle if appropriate)_____

Social History

Do you smoke currently?

Yes No

If yes, how many packs/day and for how many years have you been smoking?

_____

Have you ever smoked?

Yes No

If yes, how many packs/day and for how long did you smoke? When did you quit?

_____

Do you drink alcohol?

Yes No

If so, how many drinks per day or week do you take?

_____

Do you abuse drugs?

Yes No

If so, what drugs do you use?

_____

Patient Review of Systems

(Circle all that apply)

Constitutional
None
Change in appetite
Decreased energy
Dizziness
Fatigue
Fever
Chills
Night Sweats
Weight Loss/Gain
Sleep problems
Temperature intolerance
Unintentional weight loss

Eyes
None
Blurred vision
Double vision
Dry eyes
Itchy eyes
Bulging eyes
Loss of vision
Pain in eye
Tearing changes
Watery eyes

Ears/Nose/Mouth/Throat
None
Spinning sensation
Ear drainage
Hearing loss
Itchy ears
Ringing in ears
Nasal congestion
Nasal bleeding
Sneezing
Dry mouth
Hoarseness
Lump in throat
Difficulty swallowing

Heart
None
Blacking out
Chest pain
Heart murmur
Pounding heart
Shortness of breath
Leg swelling

Lungs
None
Cough, nonproductive
Cough, productive
Wheezing
Coughing up blood
Shortness of breath

Abdominal Disorders
None
Abdominal pain
Tarry or bloody stools
Diarrhea
Heartburn
Nausea/Vomiting
Gastrointestinal bleeding

Genitourinary
None
Unusual menstrual bleed
Flank pain
Kidney disease
Urinary frequency
Urinary Hesitancy
Dribbling with urination
Incontinence
Urinating excessive amounts

Musculoskeletal
None
Limited use of a joint
Muscle tenderness
Neck pain/stiffness
Weakness
Pain in back
Pain in joints

Neurologic
None
Change in smell
Change in taste
Change in vision
Off balance
Poor coordination
Weakness on one side of body
Numbness on one side of body
Seizures
Tremor

Endocrine
None
Excessive fatigue
Heat intolerance
Cold intolerance
Increase in neck size

Hematologic
None
Excessive bleeding
Excessive bruising
Bone pain
Masses in armpit
Masses in groin

Allergic
None
Dark circles under eyes
Hives
Recurrent Infection
Itchy nose
Sneezing