



Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: F M Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Race: \_\_\_\_\_ Language: \_\_\_\_\_

Name & Address of Primary Care (Family) Physician / Pediatrician \_\_\_\_\_

Referring Physician Name & Address (if different) \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Separated Student Status: PT FT

Home Phone \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

What is or was your occupation? \_\_\_\_\_  Retired?

Name of Spouse/Parent/Legal Guardian \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

**Primary Medical Insurance**

Policy Holder Name \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_

Plan Name \_\_\_\_\_ Policy Holder # \_\_\_\_\_ Patient's Policy # \_\_\_\_\_

Group Name (if applicable) \_\_\_\_\_ Group Number (if applicable) \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ Ins. Co. Phone Number \_\_\_\_\_

Effective Date \_\_\_\_\_ Co-pay Amount \_\_\_\_\_ Deductible \_\_\_\_\_

**Secondary Medical Insurance**

Policy Holder Name \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_

Plan Name \_\_\_\_\_ Policy Holder # \_\_\_\_\_ Patient's Policy # \_\_\_\_\_

Group Name (if applicable) \_\_\_\_\_ Group Number (if applicable) \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ Ins. Co. Phone Number \_\_\_\_\_

Effective Date \_\_\_\_\_ Co-pay Amount \_\_\_\_\_ Deductible \_\_\_\_\_

Is this visit covered by Workers' Comp? \_\_\_\_\_ No Fault? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Doctor you are here to see \_\_\_\_\_ I WILL BE PAYING BY: CASH CHECK CREDIT CARD

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

HIPAA Approved Contacts - Individuals you give permission to have access and discuss your protected health information.

ALLERGIES?  No Allergies

Allergies to Medications	Type of Reaction	Allergies to Medications	Type of Reaction

Have you ever had an allergy test?  Yes  No

Have you ever taken allergy shots?  Yes  No

If yes, are you still taking them?  Yes  No      How much relief from shots?  minimal  partial  significant

**LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) or**

Allow Adobe ENT & Allergy to obtain medication history via electronic means directly from insurer/pharmacy \_\_\_\_\_ initial here

No Current Medications

Medication	Dosage	How often taken	Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone) \_\_\_\_\_

Preferred Lab: Circle One or Input info      Sonora Quest      Labcorp      Other \_\_\_\_\_

**MEDICAL / SURGICAL HISTORY: HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?**

No Medical / Surgical History

**Cardiovascular:**      Yes      Surgery/Management

Coronary Artery Disease       \_\_\_\_\_

Elevated Cholesterol (hyperlipidemia)       \_\_\_\_\_

High Blood Pressure (hypertension)       \_\_\_\_\_

**Gastrointestinal:**

Hepatitis       \_\_\_\_\_

Hernia       \_\_\_\_\_

Gastroesophageal Reflux       \_\_\_\_\_

**Genitourinary:**

Prostate enlargement (Benign Prostate Hyperplasia)       \_\_\_\_\_

Kidney Stones (Nephrolithiasis)       \_\_\_\_\_

Renal Failure (Acute)       \_\_\_\_\_

**Ear / Nose / Throat: (HEENT)**

Cataracts       \_\_\_\_\_

Glaucoma       \_\_\_\_\_

Chronic Ear Infections (Otitis Media)       \_\_\_\_\_

Hearing Loss       \_\_\_\_\_

Sinus Problems (chronic sinusitis)       \_\_\_\_\_

Nasal Polyps       \_\_\_\_\_

Nasal Allergies       \_\_\_\_\_

Recurrent Tonsillitis       \_\_\_\_\_

Tinnitus       \_\_\_\_\_

Vertigo       \_\_\_\_\_

**Hematologic :**

Anemia       \_\_\_\_\_

If YES to any of the above Diagnosis was surgery performed?

**Immunologic:**      Yes      Surgery/Management

Allergies      Type: \_\_\_\_\_       \_\_\_\_\_

Food Allergies      Type: \_\_\_\_\_       \_\_\_\_\_

**Infectious Disease:**

Mononucleosis       \_\_\_\_\_

STD      Type: \_\_\_\_\_       \_\_\_\_\_

**Metabolic/endocrine:**

Diabetes      Type: \_\_\_\_\_       \_\_\_\_\_

Thyroid deficiency (hypothyroidism)       \_\_\_\_\_

Thyroid excess (hyperthyroidism)       \_\_\_\_\_

**Neoplastic:**

Cancer      Type: \_\_\_\_\_       \_\_\_\_\_

**Neurologic:**

Migraine       \_\_\_\_\_

**Obstetric:**

Pregnancy      Date(s): \_\_\_\_\_       \_\_\_\_\_

**Psychiatric:**

Adjustment Disorder - Anxiety       \_\_\_\_\_

Major Depression       \_\_\_\_\_

**Pulmonary:**

Asthma       \_\_\_\_\_

COPD       \_\_\_\_\_

Emphysema       \_\_\_\_\_

Sleep Apnea       \_\_\_\_\_

Tuberculosis       \_\_\_\_\_

What \_\_\_\_\_ Where/When \_\_\_\_\_ By Who \_\_\_\_\_

**FAMILY HISTORY of:**

	<u>Who</u>		<u>Who</u>		<u>Who</u>
ADD/ADHD	<input type="checkbox"/>	CVA (Stroke)	<input type="checkbox"/>	Learning disability	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Developmental delay	<input type="checkbox"/>	Migraines	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Obesity	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	Hearing deficiency	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
CAD (Coronary Artery Disease)	<input type="checkbox"/>	Hyperlipidemia	<input type="checkbox"/>	PVD	<input type="checkbox"/>
CAD-Premature	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Renal disease	<input type="checkbox"/>
Cancer Type: _____	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>

Other Family History: \_\_\_\_\_

Tobacco Use?  Yes  No  Former

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol?  Yes  No  Former

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke?  Yes  No

Caffeine Consumption?  Yes  No Type: \_\_\_\_\_ Amount per day? \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please mark where applicable:

**General health problems**

- No Yes
- Fatigue
- Fever
- Night sweats
- Weight loss
- Weight gain

**Eye problems**

- No Yes
- Double vision
- Itchy eyes
- Redness

**Ear problems**

- No Yes
- Drainage
- Hearing loss
- Infections
- Dizziness
- Itchiness
- Exposure to Excessive Noise
- Ear pain
- Ringing /noise in ears

**Nose & Sinus problems**

- No Yes
- Congestion
- Facial Pain
- Mouth Breathing
- Nose Bleeds
- Sneezing
- Runny Nose
- Post Nasal Drainage

**Mouth & Throat problems**

- No Yes
- Difficulty Swallowing
- Sleep Apnea
- Snoring
- Sore Throat
- Hoarseness
- Sores/Ulcers in Mouth

**Heart or circulation problems**

- No Yes
- Heart Murmur
- Chest pain
- Swelling of Ankles/Edema
- Blacking Out
- Irregular Heartbeat/Palpitations

**Lung or respiratory problems**

- No Yes
- Cough
- Shortness of Breath
- Wheezing

**Musculoskeletal:**

- No Yes
- Leg pain

**Stomach problems**

- No Yes
- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Nausea
- Vomiting

**Brain or Nervous system problems**

- No Yes
- Headache
- Seizures
- Focal Weakness
- Numbness

**Glands & Hormone problems**

- No Yes
- Heat Intolerance
- Cold Intolerance
- Neck Enlargement/Goiter

**Blood or Lymph nodes problems**

- No Yes
- Easy Bleeding
- Easy Bruising

**Allergy problems**

- No Yes
- Food Allergies
- Bee Sting Allergies
- Environmental Allergies
- Urticaria / Hives

**Skin**

- No Yes
- Itchy Skin/ Pruritis
- Rash
- Contact Allergy

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Hearing History Questionnaire

Please Circle the appropriate response for each system.

ringing or other sounds in ears	Yes	No
Chronic ear infections	Yes	No
Earwax build up	Yes	No
Fulness in ears	Yes	No
Pressure in ears	Yes	No
Perforated eardrum	Yes	No
Family history of hearing loss	Yes	No
Exposed to loud noises	Yes	No
Trauma to head	Yes	No
Dizziness or vertigo	Yes	No
Sinus or allergy problems	Yes	No
Have you had a hearing test?	Yes	No
Have you had ear surgery?	Yes	No

## Allergy History Questionnaire

How long have you had allergy symptoms? \_\_\_\_\_

Year Round or Seasonal? \_\_\_\_\_

Have you been allergy tested before? \_\_\_\_\_ If yes, did you receive immunotherapy? \_\_\_\_\_

Are you exposed to fumes, chemicals or dust at work? \_\_\_\_\_

What prescription medication have you tried for allergies? For How long?

Circle the appropriate number 1 to 5 severity. **0=no problem 1=Mild 5=Very severe**

Nasal Discharge	0 1 2 3 4 5	Chronic Fatigue	0 1 2 3 4 5
Nasal obstruction	0 1 2 3 4 5	Food intolerance	0 1 2 3 4 5
Watery or Itchy eyes	0 1 2 3 4 5	Frequent sinus or ear infections	0 1 2 3 4 5
Sneezing	0 1 2 3 4 5	Frequent colds or sore throats	0 1 2 3 4 5
Wheezing	0 1 2 3 4 5	Learning disability	0 1 2 3 4 5
Cough	0 1 2 3 4 5	Poor memory or concentration	0 1 2 3 4 5
Itching	0 1 2 3 4 5	Hyperactivity	0 1 2 3 4 5
Eczema	0 1 2 3 4 5	Abdominal Gas or cramping	0 1 2 3 4 5
Hives	0 1 2 3 4 5	Arthritis or muscle aching	0 1 2 3 4 5
Headache	0 1 2 3 4 5	Asthma	0 1 2 3 4 5

## Eustachian Tube Dysfunction

During the last month, how much of a problem was each of the following:

0 = no problem    2 = moderate problem    5 = very severe

Pressure in the ears	0	1	2	3	4	5
Pain in the ears	0	1	2	3	4	5
Ears feel clogged or underwater	0	1	2	3	4	5
Ear problems when you have a cold or sinusitis	0	1	2	3	4	5
Crackling or popping sounds	0	1	2	3	4	5
Ringing in the ears	0	1	2	3	4	5
Muffled feeling in the ears	0	1	2	3	4	5

Total Score \_\_\_\_\_ + 7 = Mean Item Score \_\_\_\_\_

Are these symptoms in (circle) Left Ear    Right Ear    Both Ears

**The Epworth Sleepiness Scale** is used to determine the level of your daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your ENT physician at your next visit.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep

1 = slight chance of dozing or sleeping

2 = moderate chance of dozing or sleeping    3 = high chance of dozing or sleeping

Considering the above scale, Please score each question as it describes your symptoms:

Situation	Chance of Dozing
Sitting and Reading	
Watching Television	
Sitting inactive in public space	
As a passenger in a car for an hour without a break	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
Stopped for a few minutes in traffic while driving.	