ADOBE
ENT & ALLERGY

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)

☐ **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	☐	_____

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	☐	_____

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

What_____ **Where/When**_____ **By Who**_____

FAMILY HISTORY of:	**Who**		**Who**		**Who**
ADD/ADHD	☐	CVA (Stroke)	☐	Learning disability	☐
Alcoholism	☐	Depression	☐	Mental illness	☐
Allergies	☐	Developmental delay	☐	Migraines	☐
Alzheimer's Disease	☐	Diabetes	☐	Obesity	☐
Asthma	☐	Eczema	☐	Osteoarthritis	☐
Blood disease	☐	Hearing deficiency	☐	Osteoporosis	☐
CAD (Coronary Artery Disease)	☐	Hyperlipidemia	☐	PVD	☐
CAD-Premature	☐	Hypertension	☐	Renal disease	☐
Cancer Type: _____	☐	Irritable Bowel Syndrome	☐	Seizure disorder	☐

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.	