NAME: _____ **AGE:** _____ **Birthdate:**_____ **Gender: M F**

REFERRED BY? _____ **WEIGHT:** _____ **HEIGHT:** _____

PRIMARY CARE DOCTOR: _____ **DATE:**_____

PHARMACY & Location: _____

EMAIL ADDRESS: _____ **Why? Soon, our patient portal will allow you to securely access certain elements of your health information and test results.**

Preferred method for us to contact you: Phone mail e-mail

Patient Preferred language:_____ **Ethnicity:** Hispanic Non-Hispanic

Race: American Indian Asian/Indian Alaskan Black/African American More than one race White

CHIEF COMPLAINT (main problem that you're here for today):_____

_____

CURRENT MEDICATIONS-Include over the counter (med, dosage, and frequency): If you have a list with you, please give to the receptionist so that a copy can be made and given to the nurse. I take no medications ____

ALLERGIES TO MEDICATIONS (name of medication and type of allergic reaction):

PATIENT'S PAST AND CURRENT MEDICAL PROBLEMS (please circle): Anxiety/Depression Asthma
Heart Problems Heart Attack High Blood Pressure Stroke Environmental or Food Allergies
High Cholesterol Diabetes Sleep Apnea Hypothyroidism Reflux Glaucoma Migraines
Cancer of the: _____ Need Antibiotics for Dental Procedures—why:_____
Other medical problems not listed: _____

PATIENT'S PAST SURGERIES (please circle): Adenoidectomy Tonsillectomy Sinus surgery Septoplasty
Ear Tubes Thyroid surgery Heart bypass Angioplasty Pacemaker Lung surgery Hysterectomy
Metal implants in the body--where:_____
Other surgeries not listed: _____

SOCIAL HISTORY (please circle and fill in as appropriate):

Smoking/Chewing tobacco	YES	NO	Packs/Tins per day:	_____	Number of years:	_____	Quit when? _____
Alcohol	YES	NO	Drinks per week:	_____			
Caffeine	YES	NO	Drinks per day:	_____			
Pets at home	YES	NO	What type(s)?	_____			
Pregnant	YES	NO	NOT APPLICABLE				
Daycare	YES	NO	NOT APPLICABLE				
Occupation	_____						

NAME: _____ **DATE:**_____

REVIEW OF SYSTEMS (please circle those that apply TODAY):

GENERAL:	fever/chills	weight loss/gain	fatigue
LUNGS:	cough	coughing up blood	shortness of breath
ALLERGIES:	seasonal allergy	allergy testing done	allergy shots done
EYES:	itching	tearing	blurred vision
CARDIAC:	chest pain	irregular heartbeat	murmur
GASTROINTESTINAL:	heartburn/indigestion	nausea/vomiting	swallowing difficulty
GENITOURINARY:	bloody urine	pain with urination	bedwetting (kids)
MUSCULOSKELETAL:	arthritis	muscle cramps	muscle pain
NEUROLOGIC:	dizziness	headaches	seizures
SKIN:	growths/lesions	hives	rashes
PSYCHIATRIC:	depression	anxiety	sleep disturbances
ENDOCRINE:	heat/cold intolerance	eyes bulging out	excessive thirst/hunger/urination
HEMATOLOGIC:	clotting problem	easy bruising	swollen lymph glands

FAMILY HISTORY (please circle and designate family relationship to you):
Thyroid problems _____
Environmental allergies _____
Bleeding/Clotting Problems _____
Other _____

Name of Insurance holder: _____Date of Birth:_____

Employer Name:_____ Employer Phone:_____

EMERGENCY CONTACT NAME _____ PHONE_____
Relationship to patient _____
Date_____

*******Please note that you are seeing a specialist and certain tests may be needed to be performed here in the office today, such as nasal scope, wax removal, hearing test, biopsy, CT, etc. All of these services come with additional charges. Depending on your individual insurance company and policy, these services may or may not be covered benefits. It is the patient responsibility to know your insurance coverage, and to pay your balance and your co-pay.**

If you are a self pay patient and have paid a down payment to be seen today and an additional balance remains after your visit, you will be billed for this balance.

_____
Signature of responsible party