

ENT FACULTY PRACTICE

Please print clearly

Patient Age: _____ If Patient is a minor please indicate:
Mother's Name: _____ Father's Name: _____
Mother's Occupation: _____ Father's Occupation: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work#: _____ Cell#: _____

Patient DOB: _____ Patient Sex: _____

SS#: _____ Patient Marital Status: ___Single ___Married ___Other

Email Address: _____

Emergency Contact: _____ Phone #: _____

Employer Name: _____

Address: _____

Primary Dr: _____ Referring Dr: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Fax#: _____ Fax#: _____

Pharmacy Name _____ Phone: _____

Address _____

Prescription Coverage _____ ID# _____ Phone# : _____

Insurance Information:

Primary Ins: _____ Policy #: _____ Group #: _____

Address: _____

Phone # : _____

Policy Holder Name: _____ Relation to Patient: _____

Policy Holder DOB _____ Policy Holder SS#: _____

Policy Holder Relation to Patient: _____

Secondary Ins: _____ Policy #: _____ Group #: _____

Address: _____

Phone # : _____

Policy Holder Name: _____ Relation to Patient: _____

Policy Holder DOB: _____ Policy Holder SS#: _____

***Patient Signature: _____ Date: _____

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New Patient Questionnaire

Date: _____

Name: _____ Age: _____

Reason for visit:

Length of time you had this problem: _____

Medical problems (please be specific)

Medication (Including Homeopathic, Herbal and OTC) **please be specific**

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies: _____

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Surgeries Date

Operation (Please list all)

Family Medical History

Diabetes	Yes/No	_____	High Blood Pressure	Yes/No	_____
Heart Disease	Yes/No	_____	Cancer	Yes/No	_____
Other: _____					

Social History

Do you smoke? Yes/No _____ How Much? _____

Do you drink? Yes/No _____ How Much? _____

Do you use IV drugs? Yes/No _____ How Much? _____

Occupation: _____

Review of symptoms (Circle all that apply)

General Fever	Chills	Night sweats	Dizziness	
	None	Other:		
Allergies	Hay-Fever	Dust	Pollen	Mold
	None	Other:		
Cardiovascular	Leg swelling	Heart Attack	Heart Failure	Chest Pain
	High Blood Pressure		None	Other
Endocrine	Diabetes	Thyroid		
	None	Other:		
Eyes	Blurry Vision	Double Vision	Photophobi	
	None	Blindness	Other:	
Gastrointestinal	Nausea	Vomiting	Bleeding	Diarrhea
	Liver Problems	Weight Loss	None	Other:
Genitourinary	Pain	Burning	Kidney Stones	None
	Prostate	Frequency: _____	Bleeding	Other:
Hematologic	Easy Bruising	Anemia	Blood Transfusions	
	None	Other:		
Immunologic	HIV Positive	AIDS		
	None	Other:		
Lymphatic	Nodes	Lumps		
	None	Other:		
Musculoskeletal	Pain	Swelling	Weakness	Stiffness
	Arthritis	None	Other:	
Neurological	Weakness	Numbness	Memory Problems	
	Vertigo	None	Other:	
Ob/Gyn	Pregnant	Irregular Periods	Discharge	None
	Other:	Last Gyn exam		
Psychiatric	Depression	Anxiety	Hallucinations	Suicidal
	Drug Addiction	None	Other:	
Respiratory	Asthma	Pneumonia	Cough	Sputum
	Wheezing	Tuberculosis	None	Other:
Skin	Rash	Lesion	Pain	
	None	Other:		