PATIENT MEDICAL INTAKE FORM

Name:____ Date of Birth:______/_____/______

PLEASE FILL IN THE APPROPRIATE CIRCLES (○), example : ● or an ✘

PATIENT HISTORY

CURRENT MEDICATIONS: Are you taking any medications now? ○ **Yes** ○ **No**

If yes, please list **name** and **dosage** of the medicine. Include prescription, over the counter, natural, herbals:

Name of Medicine(s)	Dosage (if known)	How often do you take it?

What is the REASON for the office visit? ____

ALLERGIES: Are you allergic to any ***MEDICATIONS***? ○ **Yes** ○ **No**

If yes, please **list** the **medication(s)** and **reaction**?

Medication:______________________________Reaction:_________________________
Medication:______________________________Reaction:_________________________
Medication:______________________________Reaction:_________________________

Have you ever had an *ALLERGY TEST*? ○ **Yes** ○ **No**

If yes, please state **where** and **when?** ___________________________Date:___/____/___

Have you ever been diagnosed with **SLEEP APNEA**? ○ **Yes** ○ **No**

If yes, did you have a sleep study? ○ **Yes** ○ **No**

Where and when? ____________________________ Date: ___/___/____

Do you use a CPAP machine? ○ **Yes** ○ **No** Tried CPAP in the Past? ○ **Yes** ○ **No**

Have you ever had a ***HEARING TEST***? ○ **Yes** ○ **No**

If yes, please state **when** and **where**? ____

Did it show a hearing loss? ○ **Yes** ○ **No**

If female, are you (or could you be) ***PREGNANT***? ○ **Yes** ○ **No**

SURGERIES: Have you ever had surgery(ies)? ○ **Yes** ○ **No**

If yes, please state **type of surgery(ies)** and **when** on the below:

Type of Surgery	**Date of Surgery** (approximate):

Have you ever been ***HOSPITALIZED?*** ○ **Yes** ○ **No**

If yes, please state **cause** and **when?**____

PAST MEDICAL HISTORY: Have you ever been diagnosed with any of the following? ○ **Yes** ○ **No**

If yes, please **mark** the following:

○ Acid Reflux	○ COPD/Emphysema	○ Hearing Loss	○ Hives
○ Allergic Rhinitis	○ Depression	○ Heart Attack/Heart Disease	○ Immunodeficiency
○ Anxiety Disorder	○ Deviated Septum	○ Hepatitis	○ Sleep Apnea
○ Asthma	○ Diabetes	○ Herpes Zoster/Shingles	○ Thyroid Disease
○ Bleeding Disorder	○ Ear Infections	○ High Blood Pressure	○ TMJ Disease
○ Cancer	○ Eczema	○ High Cholesterol	○ Tonsillitis
○ Chronic Sinusitis	○ Headaches	○ HIV/AIDS	○ Other:

FAMILY HISTORY

Father:	○ Alive	○ Deceased	○ Healthy	○ Medical problems:
Mother:	○ Alive	○ Deceased	○ Healthy	○ Medical problems:
Brother(s):	○ # Brothers: ( )		○ Healthy	○ Medical problems:
Sister(s):	○ # Sisters: ( )		○ Healthy	○ Medical problems:
Sons(s):	○ # Sons: ( )		○ Healthy	○ Medical problems:
Daughter(s)	○ # Daughters: ( )		○ Healthy	○ Medical problems:

SOCIAL HISTORY

OCCUPATION: What is your occupation? ____

○ **Full-time** ○ **Part-time** ○ **Student** ○ **Not employed** ○ **Retired** **Other:**

CAFFEINE: Do you drink caffeine? ○ **Yes** ○ **No** **Cups per day?** ○ 1 or less ○ 2-4 ○ >4

PETS: Do you have pets in the home? ○ **Yes** ○ **No** ○ Dog ○ Cat ○ Bird ○ Other:

SMOKING: Do you smoke cigarettes? ○ **Yes** ○ **No** **# Packs/day?** ○ 1/2pk ○ 1pk ○ >1-2pks

CHEWING TOBACCO: Do you chew tobacco? ○ **Yes** ○ **No**

ALCOHOL: Do you consume alcohol? ○ **Yes** ○ **No** **Drinks per week?** ○ 1 or less ○ 2-4 ○ >4

DRUGS: Do you use any recreational drugs? ○ **Yes** ○ **No** **List:**

HOBBIES: Are you active with hobbies? ○ **Yes** ○ **No** **Type of hobby?**

EXERCISE: Do you exercise? ○ **Yes** ○ **No** **How often?** ○ Once a wk ○ 2-4d/wk ○ >5d/wk

HOME LIVING SITUATION? ○ **Alone** ○ **w/ Spouse** ○ **w/Spouse & Kids** ○ **w/Kids** ○ **Other:______**

NAME: ________________________ ***Please fill in each appropriate circle (○) <u>completely</u>: example ●***

PATIENT REVIEW OF SYSTEMS			
Please indicate if you've had any of the below symptoms:			
Allergy	○ None ○ Pollens ○ Foods	○ Medication ○ Bee Venom ○ Vaccination	○ Latex ○ Other:
Cardiology (Heart)	○ None ○ High cholesterol ○ Bypass surgery	○ Catheterization ○ Chest pain ○ Taking blood thinners	○ High blood pressure ○ Palpitations ○ Other:
Constitutional (General)	○ None ○ Appetite increase ○ Fatigue	○ Fever ○ Appetite decrease ○ Weakness	○ Weight change ○ Other: ○ Other:
Dermatology (Skin)	○ None ○ Blisters ○ Poor healing ○ Dry/sensitive skin	○ Hair loss ○ Hives (itchy rash) ○ Eczema (active or inactive) ○ Itchy skin	○ Jaundice ○ Rash ○ Skin cancer (active/past) ○ Other:
Endocrine	○ None ○ Weight gain ○ Cold intolerance	○ Diabetes ○ Heat intolerance ○ Insomnia	○ Thyroid disease ○ Weight loss ○ Other:
ENT (Ear, Nose & Throat)	○ None ○ Change in voice ○ Cough ○ Dizziness	○ Nose bleeds ○ Hearing loss ○ Nasal congestion ○ Ringing in ears	○ Sinus pain ○ Sleep Apnea ○ Sore throat ○ Other:
Eyes	○ None ○ Double vision	○ Red, itchy eyes ○ Loss of vision	○ Glaucoma ○ Other:
Gastrointestinal	○ None ○ Abdominal pain ○ Bloating/belching ○ Blood in stool	○ Constipation ○ Diarrhea ○ Difficulty swallowing ○ Heartburn	○ Irritable bowel syndrome ○ Nausea ○ Vomiting ○ Other:
Hematology	○ None ○ Bleeding/Bruising	○ Blood clot in legs ○ Blood clot in lungs	○ Swollen lymph nodes ○ Other:_____________
Musculoskeletal	○ None ○ Back pain	○ Carpal tunnel ○ Joint pain	○ Neck pain ○ Other:
Neurological	○ None ○ Dizziness ○ Gait abnormality	○ Headache ○ Insomnia ○ Seizures	○ Stroke ○ Tingling/numbness ○ Other:
Psychiatric	○ None ○ Anxiety	○ Depression ○ High stress level	○ Mood swings ○ Other:
Respiratory (Lungs)	○ None ○ Albuterol inhaler ○ Asthma	○ COPD: Chronic Obstructive Pulmonary Disease ○ Chest tightness ○ Steroid inhaler / pills	○ Shortness of breath ○ Wheezing ○ Other:
Renal (Kidneys)	○ None ○ Dialysis	○ Blood in urine ○ Recurrent urinary infections	○ Difficulty urinating ○ Other:

ENT & Allergy Specialists of VA Registration Form

How did you hear about our office? (if physician, name?)________________________

What Physician are you seeing today? ○ Dr. James J. Lee ○ Dr. Vickie K. Lee

PATIENT PERSONAL INFORMATION *(please fill in all fields)*				
Please Print Clearly				
Last Name			Primary care Provider (PCP)	
First Name		MI	Referring Provider (if different than above)	
Previous Name (if any)			Date of Birth (mm/dd/yyyy)	
Address			Sex: M F (Circle one)	
City			Marital Status: Single Married Divorced Widow(er) (Circle one)	
State	Zip Code		Social Security Number	
Home Phone	Cellphone		Employer Name:	
Work phone	E-Mail		Employment status:	Student status (Y/N)

INSURANCE POLICY HOLDER INFORMATION (GUARANTOR)			
○ **Same as above**			
Last Name	First Name		MI
Date of Birth (mm/dd/yyyy)		Social Security Number	
Home Phone		Email	
Mailing Address	City	State	Zip Code
Occupation		Name of Employer	
Employers Address	City	State	Zip Code
Emergency Contact	Phone #	Relation to Patient: Self Spouse Parent Other: specify	

PRIMARY INSURANCE INFORMATION		
Name of Insurance		Effective date of Coverage
Policy Number	Co-pay	Group Number / Group Name

PHARMACY INFORMATION (Please enter your preferred pharmacy where we should send your prescriptions-we will attempt to find it in our database.)		
Name:	City:	Street:

I hereby authorize ENT & Allergy Specialists of VA to apply for benefits on my behalf for services rendered. I requested payment from the above indicated insurance carrier to be made directly to ENT & Allergy Specialists of VA. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any medical records necessary, including information for this or any related claim to the carriers indicated above.

Unless otherwise instructed, ENT & Allergy Specialists will assume that if you are married, we are authorized to disclose information about your care and benefits to your spouse (or parents, if you are a dependent child). If you disagree, please inform us immediately.

I acknowledge receiving /reading a copy of ENT & Allergy Specialists of VA, PC Notice of Privacy Practices.

Signature:____ Date _____/_____/_________