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Ear, Nose & Throat
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Patient Registration Form

Date Of Appointment _____

Patient's Information

Patient's First Name		Middle Name	Last Name	
Sex	Martial Status	Date of Birth	Social Security Number	Email Address
Patient's Address		City	State	Zip
Home Phone	Cell Phone	Pharmacy Name		Pharmacy Phone

HOW DID YOU HEAR ABOUT US?
___Doctor Name:_____
___Internet search/Site name: _____
___Insurance Name:_____
___Patient Name:_____
___Newspaper/Magazine Name:_____
___Other:_____

Pharmacy Address	
Primary Doctor Name	
Primary Doctor Address	
Primary Doctor Phone	NPI #

Reason for Visit
What brings you to the office today? _____

Employer/School	Occupation	Phone	
Employer/School Address	City	State	Zip Code
Emergency Contact Name	Emergency Phone	Relationship to Patient	

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured Employer	
Insured's Name (as appears on card)		Relationship to Patient	Insured Phone Number
Insured Address		City / State / Zip	
Insured Social Security Number	Date of Birth		

Secondary Health Insurance

Insurance Company	Plan	Plan Number	Group Number
Insured's Name (as appears on card)	Relationship to Patient	Insured Phone Number	
Insured Address	City / State / Zip		
Insured Social Security Number	Date of Birth		

Responsible Party

Name (if other than patient)	Phone	Relationship to Patient	
Address	City	State	Zip

Patient Name_____ Date of Birth_____ Date of Appointment_____

Medical Information

Have you ever been allergy tested: YES / NO
When?_____

Have you ever taken allergy shots: YES / NO
When?_____

Are you allergic to any of the following:
_____ Sulfa _____Adhesive Tape _____Codeine _____Antibiotics
_____Iodine _____Barbiturates _____ Latex _____ Aspirin

Do you have any other allergies:

Are you allergic to any of the following?
____Sulfa ____Adhesive Tape ___Codeine ____Antibiotics
____Iodine ____Barbiturates ____Latex ____Aspirin

Do you have any other allergies?

What medications are you currently taking? (include OTC, Herbal, vitamins):

Name	Dosage	Frequency	Route of Administration

Are you taking any blood thinners?

Name	Dosage	Frequency	Route of Administration

Ear, Nose & Throat

___Bleeding Gums
___Blurred Vision
___Clicking in Ears
___Crossed Eyes
___Decreased Sense of Smell
___Lumps/Knots in Neck
___Nasal Obstruction
___Neck Pain
___Decrease Sense of Taste
___Difficulty Breathing
___Difficulty Swallowing
___Dizziness
___Double Vision
___Recurring Sore Throat
___Ringing in Ears
___Sinus Problems
___Earaches or Pain
___Ear Discharge
___Facial Paralysis
___Hay Fever
___Hoarseness
___Persistent cough
___Resistant Runny Nose
___Nose Bleeds
___Sudden Hearing Loss
___Wax Removal
___Itching in Ears
___Drainage from either ear
___Snoring
___Throat Pain
___Vision Halos

About Your Hearing

Do you have a hearing problem and how long
_____
_____

Have you ever seen a doctor specializing in ears? YES / NO
If Yes, doctor name and date:_____
_____

Have you ever had any type of ear surgery? YES / NO_____
If Yes what type, where: _____
_____

Do you have a history of noise exposure? YES / NO
If Yes, what type, when? _____
_____

Have you ever had your hearing tested? YES / NO
If Yes, by whom/findings:_____
_____

Do you have difficulty with:
___Understanding all the works in a conversation clearly
___Hearing in a crowd or other noisy situations
___Hearing where background noise is present
___Hearing by telephone

Which is your weak ear: LEFT / RIGHT / SAME

Does any family member have hearing problems? YES / NO
If yes, their relationship:_____

Do you now or have you ever worn a hearing instrument? YES / NO
What Brand_____
What were the results_____

Past Medical History

___Alcoholism
___Allergies
___Anemia
___Anxiety Disorder
___Arthritis
___Asthma
___AIDS/HIV
___Back Problems
___Bleeding Disorder
___Blood Disease
___Blood Transfusion
___Cancer
___Diabetes
___Depression
___Ear Problems
___Eating Disorder
___Epilepsy
___Glaucoma
___Gout
___Heart Disease
___Hepatitis - A, B, or C
___High Blood Pressure
___High Cholesterol
___Heart Problems
___Joint Disorder
___Kidney Disorder
___Liver Disorder
___Lung Disease
___Measles
___Migraines
___Osteoporosis
___Pneumonia
___Polio
___Rheumatic Fever
___Stroke
___Skin Disorder
___Stomach Ulcer
___Thyroid Disorder
___Tuberculosis
___Venereal Disease

Hospitalizations & Surgeries

Reason	Date

Women Only

Are you pregnant? YES / NO
Are you breastfeeding? YES / NO

Patient Name_____ Date of Birth_____ Date of Appointment_____

Family History

Has anyone in your family had any of the following conditions?

__Alcoholism
__Allergies
__Alzheimer's
__Anemia
__Anxiety
__Arthritis
__Asthma
__AIDS/HIV
__Bleeding Disorder
__Blood Disorder
__Cancer
__Depression
__Diabetes
__Epilepsy
__Genetic Disorder
__Glaucoma
__Heart Disease
__Hepatitis
__High Cholesterol
__High Blood Pressure
__Joint Disorder
__Kidney Disease
__Liver Disorder
__Lung Disease
__Migraines
__Psychiatric Disorder
__Osteoporosis
__Stroke
__Substance Abuse
__Thyroid Disorder

Additional Details: _____

Lifestyle Factors

Have you ever smoked? YES / NO
No. of Years_____
Do you smoke now? YES / NO
Packs a day_____
Do you use recreational drugs? YES / NO
Type_____Amount_____
Do you drink alcohol? YES / NO
Amount _____
Do you drink caffeine? YES / NO
Amount_____

Review of Systems

General
__Chills
__Dizziness
__Fainting
__Fever
__Hair Loss
__Hair Growth
__Night Sweats
__Sleeping Problems
__Thirst-Excessive
__Weight Gain
__Weight Loss

Cardiovascular
__Chest Pains
__Irregular Hear Beat
__Circulation Problems
__Heart Palpitation
__Rapid Heartbeat
__Swelling of Ankles
__Varicose Veins

Gastrointestinal
__Appetite Gain
__Appetite Loss
__Bloating
__Bowel Changes
__Constipation
__Diarrhea
__Gas
__Hemorrhoids
__Indigestion
__Lactose Issues
__Nausea
__Rectal Bleeding
__Stomach Pain
__Vomiting
__Vomiting Blood

Skin
__Chills
__Acne
__Bruise Easily
__Changes in Moles
__Dry/Sensitive
__Eczema
__Hives
__Itching
__Rash
__Scars
__Sores, non-healing

Genitourinary
__Blood in Urine
__Lack of Bladder Control
__Frequent Urination
__Painful Urination

Neurological
__Coordination Issues
__Convulsions
__Difficulty Walking
__Learning Disabilities
__Light-headedness
__Memory Loss
__Numbness/Tingling
__Paralysis
__Seizures
__Tremors

Respiratory
__Coughing
__Coughing Up Blood
__Shortness of Breath
__Wheezing

Mental Health
__Anxiety
__Depression
__Loss of Interest
__Feeling of Hopelessness
__Hearing Voices
__Marital Problems
__Panic Attacks
__Trouble Concentrating
__Suicide Thoughts/Attempts

Women Only
__Abnormal Pap Smear
__Bleeding between Periods
__Breast Lump
__Extreme Menstrual Pain
__Hot Flashes
__Nipple Discharge
__Painful Intercourse
__Vaginal Discharge

Musculoskeletal
__Back Pain
__Carpal Tunnel
__Joint Pain
__Joint Swelling
__Neck Pain
__Shoulder Pain

Other Symptoms _____