Gainesville ENT and Allergy Associates

Name:	**DOB:**	**SSN:**
Insurance:		
Subscriber (if different than patient):		**Subscriber DOB:**
Emergency Contact:	**Contact's phone number:**	
Allow the following person(s) access to my medical records:		
Questions for Government Meaningful Use Compliance: (please circle one)		
Preferred language: English, Indian, Russian, Spanish, Other		
Race: American Indian, Asian, African American, White, Other, Refuse to report		
Ethnicity: Hispanic/Latino, Non-Hispanic/Non-Latino, Refuse to report		
Marital status: Married, divorced, single, widowed, separated, partner, other		
Email address:		
Pharmacy:	**Primary care physician:**	
Referring Physician/How did you hear about us:		
Reason for today's visit:		
Height:	**Weight:**	

Medical History: (please circle one)				**Other Medical History/Explanations:**
Cancer - Other (Please Explain)	:	yes	no	
Cancer - Skin	:	yes	no	
Heart Disease	:	yes	no	
High Blood Pressure	:	yes	no	
High Cholesterol	:	yes	no	
Irregular Heart Beat	:	yes	no	
Eczema	:	yes	no	
Other Rash (Please Explain)	:	yes	no	
Psoriasis	:	yes	no	
Hearing Loss	:	yes	no	
ENT - Other (Please Explain)	:	yes	no	
Allergies/Allergic Rhinitis	:	yes	no	
Diabetes	:	yes	no	
Osteoporosis	:	yes	no	
Thyroid Problems	:	yes	no	
Cataracts	:	yes	no	
Glasses/Contacts	:	yes	no	
Glaucoma	:	yes	no	
Eyes - Other (Please Explain)	:	yes	no	
GI - Other (Please Explain)	:	yes	no	
Reflux	:	yes	no	
Stomach Ulcers	:	yes	no	
Bleeding Disorder	:	yes	no	
Hematology - Other (Please Explain)	:	yes	no	
Immunodeficiency	:	yes	no	

Recurrent Infections	:	yes	no	
Diagnosed Migraines	:	yes	no	
Headaches	:	yes	no	
Neuropathy	:	yes	no	
Seizures/Epilepsy	:	yes	no	
Stroke/TIA	:	yes	no	
Degenerative Joint Disorder	:	yes	no	
Anxiety	:	yes	no	
Depression	:	yes	no	
Asthma	:	yes	no	
COPD/Emphysema	:	yes	no	
Diagnosed Sleep Apnea	:	yes	no	on CPAP or BiPAP?
Snoring	:	yes	no	
Arthritis	:	yes	no	
Autoimmune Disease (Please Explain)	:	yes	no	
Chronic Pain	:	yes	no	
Fibromyalgia	:	yes	no	
BPH (Prostate Problems)	:	yes	no	
Kidney Disease	:	yes	no	
Additional Medical History (please list any additional medical conditions that were not listed above)				
FAMILY (other than yourself) Medical History: (please list relative if "yes" is circled)				
anesthetic reaction	:	yes	no	
bleeding disorders	:	yes	no	
head or neck cancer	:	yes	no	
allergies	:	yes	no	
hearing loss	:	yes	no	
Social History: please circle all that apply, notate quantity used and/or notate when quit				
Are you a	:	Never smoker, former smoker, current every day smoker, current some day smoker		
tobacco	:	yes	no	packs per day for ___ years; quit _____.
smokeless tobacco	:	yes	no	packs per day for _____ years; quit _____.
alcohol	:	yes	no	drinks per day for _____ years; quit _____.
illicit drug use	:	yes	no	
Surgical History:				

Please list any medication allergies:

Please list all medications that you are currently taking (including over-the-counter):

Please circle yes or no to indicate any symptoms that you are CURRENTLY experiencing:

chills	:	yes	no	irregular heartbeat	:	yes	no
fever	:	yes	no	hypertension	:	yes	no
weight loss	:	yes	no	valve problem	:	yes	no
				heart disease	:	yes	no
headache	:	yes	no				
				liver disease	:	yes	no
eyesight problems	:	yes	no	difficulty urinating	:	yes	no
glasses/contacts	:	yes	no				
glaucoma	:	yes	no	arthritis	:	yes	no
				artificial joint	:	yes	no
ringing in ears	:	yes	no				
discharge from ears	:	yes	no	dizziness	:	yes	no
hearing loss	:	yes	no	neurological disease	:	yes	no
wears hearing aids	:	yes	no				
earache	:	yes	no	rash or itching	:	yes	no
				skin cancer	:	yes	no
nose bleed	:	yes	no				
nasal congestion	:	yes	no	anxiety	:	yes	no
allergies/hay fever	:	yes	no	depression	:	yes	no
snoring	:	yes	no				
				thyroid disorder	:	yes	no
mouth sores	:	yes	no	diabetes	:	yes	no
hoarseness	:	yes	no				
loose/broken teeth	:	yes	no	anemia	:	yes	no
difficulty swallowing	:	yes	no	bruising/bleeding	:	yes	no
dentures	:	yes	no	swollen glands	:	yes	no
				taking blood thinners	:	yes	no
wheezing	:	yes	no	religious needs regarding blood transfusion	:	yes	no
chronic cough	:	yes	no				
coughing up blood	:	yes	no				
diagnosed sleep apnea	:	yes	no	HIV	:	yes	no
				hepatitis	:	yes	no
shortness of breath	:	yes	no	MRSA	:	yes	no
pacemaker	:	yes	no				