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

PAST 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)				

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		
chronic cough :	yes	no	blood transfusion :	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			