Gainesville ENT and Allergy Associates

Patient's name:	**DOB:**	**SSN:**
Parent/guardian name:		
Insurance:		
Subscriber (if different than patient):		**Subscriber DOB:**
Emergency Contact:	**Contact's phone number:**	
Allow the following person(s) access to patient's 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 all past medical conditions:	

FAMILY (other than patient) 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	

Surgical History:	

Please list any medication allergies:	

Please list all medications that the patient is currently taking (including over-the-counter):

Please circle yes or no to indicate any symptoms that the patient is CURRENTLY experiencing:

fevers / chills	:	yes	no	irregular heart beat	:	yes	no
unexplained weight loss	:	yes	no	heart murmur	:	yes	no
headaches	:	yes	no	diagnosed bleeding disorder	:	yes	no
seizures / epilepsy	:	yes	no	easy bruising / bleeding	:	yes	no
developmental delay	:	yes	no				
if yes, please explain	:			acid reflux	:	yes	no
cleft lip or palate	:	yes	no	other GI issues	:	yes	no
				if yes, please explain	:		
glasses/contacts	:	yes	no				
other vision problems	:	yes	no	anxiety	:	yes	no
if yes, please explain	:			depression	:	yes	no
				ADD / ADHD	:	yes	no
seasonal allergies	:	yes	no				
nosebleeds	:	yes	no	diabetes	:	yes	no
inability to breathe through nose	:	yes	no	thyroid problems	:	yes	no
hearing loss	:	yes	no	immunodeficiency	:	yes	no
other ENT issues	:	yes	no	immunizations up to date	:	yes	no
if yes, please explain	:						
				recurrent infections	:	yes	no
eczema	:	yes	no				
other rash	:	yes	no	autoimmune disease	:	yes	no
If yes, please explain	:						
				joint pain	:	yes	no
diagnosed asthma	:	yes	no				
recurrent croup	:	yes	no	difficulty urinating	:	yes	no
snoring	:	yes	no	bed wetting	:	yes	no