Gainesville ENT and Allergy Associates

Patient name:	**DOB:**

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