ENTICARE
Ear · Nose · Throat

REASON FOR TODAY'S VISIT: _____ DATE: _____

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ /_____ / _____ Age: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Mailing Address: _____ City: _____ State:_____ Zip: _____

Other Address: _____ City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred method for appointment reminders (check all that apply): ❑ Home Phone ❑ Cell Phone ❑ Text ❑ Email

Email (print clearly): _____

Pharmacy Name & City:_____ Cross Street: _____ Phone:_____

REFERRAL INFORMATION:

Referring Facility:_____ Address / Location:_____

Referring Provider Full Name: _____Phone: _____

Primary Care Physician Full Name:_____ Phone:_____

❑ **SELF PAY**

Responsible Party/Guardian (if patient is a minor): _____Phone: _____

PRIMARY INSURANCE CO: _____ ID / Policy #: _____

Policy Holder Name: _____Group #:_____

Relationship to Patient: _____ DOB: _____ /_____ / _____

SECONDARY INSURANCE CO: _____ ID / Policy #: _____

Policy Holder Name: _____Group #:_____

Relationship to Patient: _____ DOB: _____ /_____ / _____

Federal Privacy Standards require the following information:

Race: ❑ White ❑ Hispanic ❑ Asian ❑ African American ❑ American Indian / Alaskan Native
❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Unreported / Refused to Report

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Refused to Report

Preferred Language: ❑ English ❑ Spanish ❑ Other

HIPAA APPROVED CONTACTS:

- *Please list the individuals you give permission to have access to and discuss your protected health information.*
- *Write **'NONE'** if there are no authorized individuals.*

Name	Date of Birth	Phone Number	Relationship	Emergency Contact
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No

What is your Height?_____ Weight?_____

MEDICATIONS: ❑ None

- *Please list all the medications you are taking, including supplements (attach list as needed).*

ALLERGIES: ❑ None

Are you allergic to: ❑ Latex ❑ Contrast Dye ❑ Adhesive Tape ❑ Iodine

- *Please list any medications you are allergic to and how each affects you.*

SURGERY HISTORY: ❑ None

Have you ever had problems with anesthesia? ❑ Yes ❑ No

Please explain:_____

_____

PROCEDURE	DATE (MO/YR)

FAMILY HISTORY: ❑ None

Please list any family history of your **Father, Mother, Siblings, Children** and **Grandparents**.

CONDITION	RELATIONSHIP
Problems with anesthesia	
Thyroid disease	
Thyroid cancer	
Throat cancer	
Other cancer:	
Early hearing loss	
Heart disease	
High blood pressure	
Diabetes	
Stroke	
Asthma	
Kidney problems	
Bleeding / Clotting problems	
Other:	

SOCIAL HISTORY:

Are you a: ❑ Non-smoker ❑ Former Smoker ❑ Current Smoker

If **'Former Smoker':**

How long did you smoke?_____

When did you quit? _____

If **'Current Smoker':**

How many packs per day do you smoke? _____

How long have you smoked? _____

Are you interested in quitting? ❑ Yes ❑ No

Do you drink? ❑ Yes ❑ No

If **'Yes':** How often do you drink? ❑ Daily ❑ Few per week/mo ❑ Rarely

RECREATIONAL DRUG USE:

❑ Never ❑ Previous ❑ Current

Drug: _____

Last Used: _____

Female Patients Only:

Are you now or is there a chance that you are pregnant? ❑ Yes ❑ No

MEDICAL HISTORY: **ALL PATIENTS**

Have you ever been **DIAGNOSED** with any of the following conditions?

Acid reflux (GERD)	❑ Yes	❑ No
Alcohol abuse	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Atrial fibrillation	❑ Yes	❑ No
Bronchitis, chronic	❑ Yes	❑ No
Cancer, breast	❑ Yes	❑ No
Cancer, lung	❑ Yes	❑ No
Cancer, prostate	❑ Yes	❑ No
Cancer, skin	❑ Yes	❑ No
Cancer, thyroid	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No
Congestive heart failure	❑ Yes	❑ No
Deep vein thrombosis (DVT)	❑ Yes	❑ No
Dementia	❑ Yes	❑ No
Depression	❑ Yes	❑ No
Diabetes mellitus	❑ Yes	❑ No
Elevated cholesterol	❑ Yes	❑ No
Emphysema (COPD)	❑ Yes	❑ No
Environmental allergies	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No
Gastric ulcer	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Heart attack or cardiac stents	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No
Hepatitis B	❑ Yes	❑ No
Hepatitis C	❑ Yes	❑ No
HIV / AIDS	❑ Yes	❑ No
Hypertension	❑ Yes	❑ No
Migraine headaches	❑ Yes	❑ No
Multiple sclerosis	❑ Yes	❑ No
Parkinson's disease	❑ Yes	❑ No
Pulmonary embolism (PE)	❑ Yes	❑ No
Renal failure	❑ Yes	❑ No
Rheumatoid arthritis	❑ Yes	❑ No
Sleep apnea	❑ Yes	❑ No
Stroke	❑ Yes	❑ No

Other: _____

REVIEW OF SYMPTOMS:

Do you **NOW** have any of the following symptoms?

Fatigue	❑ Yes	❑ No
Fever	❑ Yes	❑ No
Headache	❑ Yes	❑ No
Sleep disturbance	❑ Yes	❑ No
Weight gain	❑ Yes	❑ No
Weight loss	❑ Yes	❑ No
Congestion	❑ Yes	❑ No
Sneezing	❑ Yes	❑ No
Runny nose	❑ Yes	❑ No
Watery eyes	❑ Yes	❑ No
Blurred vision	❑ Yes	❑ No
Diminished visual acuity	❑ Yes	❑ No
Itching and redness	❑ Yes	❑ No
Decreased hearing	❑ Yes	❑ No
Decreased sense of smell	❑ Yes	❑ No
Difficulty swallowing	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Ear pain	❑ Yes	❑ No
Nose bleed	❑ Yes	❑ No
Ringing in ears	❑ Yes	❑ No
Sinus pain	❑ Yes	❑ No
Sore throat	❑ Yes	❑ No
Swollen glands	❑ Yes	❑ No
Cough	❑ Yes	❑ No
Shortness of breath at rest	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No
Irregular heartbeat	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No
Nausea	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Easy bruising	❑ Yes	❑ No
Prolonged bleeding	❑ Yes	❑ No
Joint stiffness	❑ Yes	❑ No
Leg cramps	❑ Yes	❑ No
Muscle aches	❑ Yes	❑ No
Eczema	❑ Yes	❑ No
Hives	❑ Yes	❑ No
Rash	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Tremors	❑ Yes	❑ No

EUSTACHIAN TUBE DYSFUNCTION

During the last month, how much of a problem was each of the following:

0 = no problem | 2 = moderate problem | 5 = very severe

Pressure in the ears	0	1	2	3	4	5
Pain in the ears	0	1	2	3	4	5
Ears feel clogged or underwater	0	1	2	3	4	5
Ear problems when you have a cold or sinusitis	0	1	2	3	4	5
Crackling or popping sounds	0	1	2	3	4	5
Ringing in the ears	0	1	2	3	4	5
Muffled feeling in ears	0	1	2	3	4	5

Total Score _____ **+ 7 = Mean Item Score**_____

Are these symptoms in : ❑ Left ear only ❑ Right ear only ❑ Both ears

THE EPWORTH SLEEPINESS SCALE

- How likely are you to doze off or fall asleep in the following scenarios in contrast to just feeling tired?
- Even if have not done some of these thing recently, try to work out how they would have affected you.
- Use the scale to choose the most appropriate number for each situation and circle the correct one.

0 = Would Never Doze
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

SCENARIO	CHANCE OF DOZING
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in public place, e.g., theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
In a car, while stopped in a few minutes of traffic	0 1 2 3

HEARING HISTORY QUESTIONNAIRE

Please circle the appropriate response for each symptom.

Ringing or other sounds in ears	Yes	No
Chronic ear infections	Yes	No
Earwax build up	Yes	No
Fullness in ears	Yes	No
Pressure in ears	Yes	No
Perforated eardrum	Yes	No
Family history of hearing loss	Yes	No
Exposed to loud noises	Yes	No
Trauma to head	Yes	No
Dizziness or vertigo	Yes	No
Sinus or allergy problems	Yes	No
Have you had a hearing test?	Yes	No
Have you had ear surgery?	Yes	No

ALLERGY HISTORY QUESTIONNAIRE

How long have you had allergy symptoms? _____

Year-round or seasonal?_____

Have you been allergy tested before? _____

If yes, did you receive immunotherapy? _____

Are you exposed to fumes, chemicals or dust at work?_____

What prescription medication have you tried for allergies? For how long?

PRESCRIPTION	FOR HOW LONG

Please circle the appropriate number 1-5 according to severity:

0 = no problem | 1 = mild | 5 = very severe

Nasal discharge	0 1 2 3 4 5
Nasal obstruction	0 1 2 3 4 5
Watery or itchy eyes	0 1 2 3 4 5
Sneezing	0 1 2 3 4 5
Wheezing	0 1 2 3 4 5
Cough	0 1 2 3 4 5
Itching	0 1 2 3 4 5
Eczema	0 1 2 3 4 5
Hives	0 1 2 3 4 5
Headache	0 1 2 3 4 5
Chronic fatigue	0 1 2 3 4 5
Food intolerance	0 1 2 3 4 5
Frequent sinus or ear infections	0 1 2 3 4 5
Frequent colds or sore throats	0 1 2 3 4 5
Learning disability	0 1 2 3 4 5
Poor memory or concentration	0 1 2 3 4 5
Hyperactivity	0 1 2 3 4 5
Abdominal gas or cramping	0 1 2 3 4 5
Arthritis or muscle aching	0 1 2 3 4 5
Asthma	0 1 2 3 4 5