Valley Ear, Nose and Throat Specialists, P.A.

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PATIENT INFORMATION SHEET
(PLEASE PRINT)

Patient Name: _____ **Height**:_____ **Weight**:_____ Male Female

Date of birth: _____/_____/_____ Age: _____ SS#_____-_____-_____

Mailing address: _____ City:_____ State:_____ Zip:_____

H/ Ph #: ( )_____ M/ Ph #: ( )_____ W/ Ph #: ( )_____

If patient is a minor: **Parent/Guardian Name**: _____

Email Address: _____

Parent/Guardian: Date of birth: _____ **Parent/Guardian SS#**_____-_____-_____

Spouse's Name: _____ Phone #: ( )_____

Race: Hispanic/Latino Caucasian Asian Black/African American American Indian/Alaska Native Chinese East Indian Filipino Japanese Native Hawaiian Pacific Islander Multiracial Other: _____

Did a doctor refer you for today's visit? YES NO

If yes, please give Physicians name:_____ Phone#: ( )_____

Are you under the care of a Primary Care Physician? YES NO

If yes, please give Physicians name: _____ Phone#: ( )_____

Please indicate the reason for your visit today: _____

Is the patient up to date with immunizations? YES NO

Does the patient have ear infections? YES NO
If yes, how many infections have you had in the past year? _____
Which antibiotics have been given to treat these ear infections? _____
Is the child enrolled in daycare? YES NO

Does the patient have a history of speech delay? YES NO How many words can the patient say? _____
Is the patient currently enrolled in speech therapy? YES NO

Does the patient have a history of tonsil/throat infections? YES NO
If yes, how many infections have you had in the past year? _____
Which antibiotics have been given to treat these tonsil/throat infections? _____

Does the patient have a history of sinus infections? YES NO
If yes, how many infections have you had in the past year? _____
Which antibiotics have been given to treat these sinus infections? _____

Do you have nosebleeds? YES NO

What symptoms do you have? (Circle all that apply)

Facial Pain	Headaches	Post-Nasal Drip	Difficulty Breathing
Nasal Congestion	Facial Pressure	Ear Congestion	Facial Swelling

Do you have any other medical problems? Please list: _____

_____

Have you ever had surgeries? Please list:

Surgery	Year of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name: _____ Date of birth: _____/_____/_____

Has the patient ever had an adverse reaction to latex? YES NO

Do you smoke? (Currently) (Never) (In the past)
If currently, how many packs/cigars per day? _____ How long? _____

Do you chew tobacco? YES NO If yes, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____

Do members of your family have any medical problems? Please list: _____
_____
_____

Indicate which of the following medical problems you have had or have at present time. Please circle all that apply.

Abnormal scarring	Dizziness	Hepatitis B	Rapid heart beat
AIDS	Drug addiction	High blood pressure	Recurrent pneumonia
Anemia	Ear Fullness	HIV	Regurgitation of food/liquid
Arthritis	Ear pain	Hoarseness	Rheumatic fever
Artificial heart valve	Emphysema	Jaundice	Ringing in the ear
Asthma	Epilepsy/Seizures	Joint swelling	Runny nose
Blood transfusion	Fainting	Liver disease	Sinus pressure
Bruise easily	Failure to thrive	Loss of voice	Sinus trouble
Burning in throat	Fatigue	Lump in throat	Skin rashes
Cancer throat/head/neck	Fever	Mental Retardation	Slow heart beat
Cerebral Palsy	Food sticking in throat	Movement disorder	Snoring
Chest pain	G-Tube	Multiple Sclerosis	Sore throat
Choking	Glaucoma	Nausea/Vomiting	Spitting up blood
Chronic cough	Hay fever	Nasal bleeding	Stomach ulcers
Chronic throat clearing	Head injury	Nasal congestion	Strokes
Cold sores	Headache	Nervousness	Throat drainage
COPD	Hearing loss	Neurodegenerative disease	Throat trauma
Dementia	Heart disease/attacks	Night waking with cough	Thyroid disease
Diabetes	Heart murmur	Pain in jaw joint	Tuberculosis
Difficulty breathing	Heart pacemaker	Painful swallowing	Trach
Difficulty swallowing	Heartburn or Reflux	Parkinson's disease	Venereal disease
Difficulty urinating	Hemophilia	Pneumonia	Voice Changes
Discharge from the ear	Hepatitis A	Psychiatric treatments	Weight Loss

FOR WOMEN ONLY:
Are you pregnant? YES NO **If YES, how many months?** _____

I UNDERSTAND THE ABOVE INFORMATION IN NECESSARY TO PROVIDE ME WITH MEDICAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE.

_____ _____
PATIENT SIGNATURE/RESPONSIBLE PARTY SIGNATURE **DATE**