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

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Dr. Keith A. Picou ● Dermatologist-Otorhinolaryngologist

PATIENT INFORMATION SHEET

(PLEASE PRINT)

Patient Name: _____Weight:_____Height:_____ Male Female

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

Mailing address: _____City:_____ State:_____ Zip:_____

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

Email Address: _____

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

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

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

Emergency Contact:_____ Relationship: _____Phone #: ( )_____

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

If yes, please give Physician's name:_____ Phone#: ( )_____

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

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

1) How did you hear about Valley Ear, Nose & Throat Specialists?

   □ Physician □ Patient □ YP □ Website □ Radio □ TV □ Other: _____

2) Please indicate the reason of your visit today? _____

3) How long have you had this problem? _____

4) Where on your body is your skin problem? _____

5) What medication(s) are being taken for this problem? _____

6) Are you allergic to latex? ( ) YES ( ) NO

7) If female, are you pregnant? ( ) YES ( ) NO

8) Do you have any of the following?

( ) Arthritis	( ) Hepatitis	( ) Pacemaker
( ) Asthma	( ) HIV (AIDS virus)	( ) Skin cancer
( ) Diabetes	( ) Hives	( ) Stomach ulcer
( ) Hay Fever	( ) Hypertension	
( ) Heart condition	( ) Internal cancer	

9) Please list all other medication(s) you are taking: _____

_____

10) Please list all surgeries and/or hospitalizations: _____

_____

PLEASE READ THE FOLLOWING AND SIGN

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

_____ _____

Patient Signature or Parent/Guardian if patient is a minor Date