Patient's Last Name: _____ First: _____ MI: _____

Street Address: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

How were you referred to us: ☐Social Media ☐Internet ☐Physician referral: _____

Sex: ☐Male ☐Female Date of Birth: _____ Height: _____ Weight: _____

Race: ☐White ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐Asian

☐American Indian or Alaska Native ☐Other

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino Preferred Language: _____

Patients 18 and older only – Are you a smoker Yes or No (circle one)

Patients 65 and older only – Have you had a Pneumonia Vaccination Yes or No (circle one)

Patients 50 and over only – Have you had a Colonoscopy Yes or No (circle one) Year: _____

Female patients over 40 only – Have you had a Mammogram Yes or No (circle one) Year: _____

Female patients 23-64 – Have you had Cervical Cancer Screening Yes or No (circle one) Year: _____

Please List any medications you are taking: Pharmacy:_____

Name of Medication	Dosage	How often taken

Are you allergic to any medications? _____ YES ____ NO

Name of Medication	Type of Reaction

Patient's Last Name: _____ First: _____ MI: _____

Surgeries and Hospitalization

Have you ever had any problems with anesthesia (being put to sleep) _____ Yes _____ No

If yes, Please List the type of Problems: _____

List any surgeries you have had:

Type of Surgery	Date

Previous Allergy testing: _____ Yes _____ No Where was it done: _____

Previous CT Scans: _____ Yes _____ No Where was it done: _____

Previous US of Thyroid _____ Yes _____ No Where was it done: _____

Do you use a Saline Irrigation kit _____ Yes _____ No

Reason for Visit today? _____

I give consent to Ear, Nose, Throat and Allergy Specialists to obtain my Prescription History (prescriptions given in the past) my health plan or pharmacy.

☐Yes ☐No

_____ _____

Patient Signature **Date**

Release of information: Please indicate any additional parties we are allowed to speak with regarding your account and release of medical information (Please Circle)

- Spouse? Name _____ Yes No
- Immediate Family? Name _____ Yes No
- Other? Name _____ Yes No
- Can we leave a message on your answering machine/Voicemail Yes No