

ROCKWOOD CLINIC ENT NEW PATIENT FORM

Please print this form, fill it out, and bring it with you to your scheduled appointment

Patient Name: _____ Age: _____

Phone: (h) _____ (w) _____ Date: _____

Primary Care Provider: _____ Who referred you? _____

Please circle who is filling out this form: Patient Mother Father Relative Guardian Attendant

What symptom bothers you the most? _____

Are you allergic to any medications: YES / NO Latex? YES / NO

If yes, which medications, and what is the reaction?

- 1 _____ reaction: _____
- 2 _____ reaction: _____
- 3 _____ reaction: _____

Present Medications: List, or ask the receptionist to copy your list of medications/herbs/vitamins

- 1 _____ Dosage: _____
 - 2 _____ Dosage: _____
 - 3 _____ Dosage: _____
 - 4 _____ Dosage: _____
 - 5 _____ Dosage: _____
- Blood Thinners? _____ Dosage: _____

List surgeries of any kind with approximate date:

- Tonsillectomy? Y / N Date: _____ Adenoidectomy? Y / N Date: _____
Sinus Surgery? Y / N Date: _____ Ear Surgery? Y / N Date: _____
- 1 _____ Date: _____
 - 2 _____ Date: _____
 - 3 _____ Date: _____

Hospitalizations for problems other than surgery or childbirth:

- 1 Date: _____ For: _____
- 2 Date: _____ For: _____

Past Medical History: Do you have or have you ever had:

	Yes	No	Yes	No
Premature Birth/Neo-natal ICU	Yes	No	Blood clots in legs	Yes No
HIV/AIDS	Yes	No	High blood pressure	Yes No
Hepatitis	Yes	No	Snoring	Yes No
Reflux/Heartburn	Yes	No	Testing in sleep lab	Yes No
Ulcers	Yes	No	Sleep apnea	Yes No
Diabetes, Type _____	Yes	No	Cancer: _____	Yes No
Bleeding Tendencies	Yes	No	Stroke (when) _____	Yes No
Blood Transfusions	Yes	No	Seizures, (when) _____	Yes No
Asthma	Yes	No	Kidney disease/stones	Yes No
Tuberculosis	Yes	No	Arthritis	Yes No
Heart Attack, when _____	Yes	No	Thyroid gland disease	Yes No
Congestive Heart Failure	Yes	No	Type: _____	
Cardiac Pacemaker	Yes	No	Radiation to head or neck	Yes No
Heart Valve Disease	Yes	No	(other than x-rays/scans)	
Rhythm Disturbances	Yes	No	Headache, type: _____	Yes No
Chest Pain	Yes	No	Head Trauma, serious	Yes No
			Type: _____	

REVIEW OF SYMPTOMS:

Do you have problems with?

Inappropriate sleepiness			Voice change/hoarseness	Yes	No
during the day	Yes	No	Hay fever (environmental allergies)	Yes	No
Double vision	Yes	No	Allergies/food	Yes	No
Equilibrium/dizziness	Yes	No	Swallowing, difficult or painful	Yes	No
Numbness,(where) _____	Yes	No	Choking on swallowed liquids	Yes	No
Paralysis, (where) _____	Yes	No	Weight loss, unexplained	Yes	No
Cough, since _____	Yes	No	Difficulty urinating	Yes	No
Short of breath at rest	Yes	No			
Difficulty breathing in the nose	Yes	No			
which side: _____					

Other urinary tract problems: _____

Other cardiac problems: _____

Skin problems: _____

Bone/joint problems: _____

Hormonal problems: _____

Other nervous system problems: _____

Mental health issues: _____

Blood cell production/clotting: _____

FAMILY HISTORY:

Are your parents alive?

Mother	Yes	No	Cause of death _____
Father	Yes	No	Cause of death _____

Parents health problems:

Mother _____

Father _____

Does anyone in your family suffer from:

Bleeding disorders	Yes	No	Allergies	Yes	No
Hearing loss	Yes	No	Cancer, _____	Yes	No
Severe reactions to anesthesia	Yes	No	Inherited syndromes	Yes	No
Thyroid disease	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Heart disease	Yes	No

SOCIAL HISTORY

Do you currently smoke?	Yes	No	How much _____	How long _____
Have you smoked much in the past?	Yes	No	How much _____	How long _____
Do you chew tobacco?	Yes	No	How much _____	How long _____
Do you drink alcohol?	Yes	No	How much _____	How long _____
	Yes	No	How much _____	How long _____

OCCUPATIONAL HISTORY:

Current employment or main activity: _____

Females of child bearing age: Pregnant? Yes No

IS THERE ANYTHING ELSE YOU WOULD LIKE THE DOCTOR TO KNOW?

Questions or concerns? Please feel free to call the Rockwood Clinic ENT Department at (509) 838-2531 ext.3400 or 1-800-772-4048 ext.4300.

The Rockwood Clinic ENT Department is located on **3W** in the Main Rockwood Clinic at **400 East 5th Avenue.**