ARLINGTON ENT ASSOCIATES, PC.

1635 N. GEORGE MASON DR. SUITE 250, ARLINGTON, VA 22205

703-524-1212

***PATIENT INFORMATION***

LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARTIAL STATUS: \_\_ SINGLE \_\_MARRIED \_\_SEPARATED \_\_DIVORCED \_\_WIDOWED

***INSURANCE POLICY HOLDER (If you are not the policy holder)***

**PRIMARY INSURANCE COVERAGE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POLICY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP#

LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE COVERAGE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POLICY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP#

LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF MEDICARE PATIENT: ARE YOU IN AN ASSISTANT LIVING HOME? \_\_\_ YES \_\_\_NO

REFERRING PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP, IF DIFFERENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***IN CASE OF EMERGENCY, PLEASE CONTACT:***

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_

***PHARMACY INFORMATION***PHARMACY NAME/STORE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHARMACY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***INFORMATION AUTHORIZATION AND INSURANCE ASSIGNMENT***

I hereby authorize Arlington ENT Associates, P.C. to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company be made directly to Arlington ENT Associates, P.C. I hereby authorize Arlington ENT Associates, to release information concerning my diagnosis, treatment and prognosis of any illness or injury I now have or have had in the past tot my insurance carrier and their representatives or to any health care or legal professional involved in my treatment.

**ASSUMPTION OF RESPONSIBILITY:** The undersigned agrees, whether he signs as agent or patient, that in consideration of services to be rendered to the patient names above, he hereby obligates himself and agrees to pay upon demand to above-named PROVIDER all charges for such services and incidentals incurred by said patient. If patient does not pay the entire account balance within 30 days of the monthly billing date, this account becomes delinquent. Should the account be referred to an attorney for collection, the undersigned shall pay attorney fees and collection expenses. All delinquent accounts will be assessed interest at the legal rate. It is understood that bills are payable upon presentation.

I also hereby assign to Arlington ENT Associates, P.C. physicians all payment for medical services rendered by them for my care. I understand that I am responsible for any charges not covered by my insurance carrier. A copy of this authorization will be as valid as the original.

PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GUARDIAN, IF MINOR PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT ACCOUNT # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(FOR OFFICE USE ONLY)**

**HIPPA STATEMENT OF PRIVACY PRACTICES**

Our office is dedicated to the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised as a principal concept of our practice. We may, from time to time amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

***Protecting Your Personal Health Information***

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Virginia. This includes issue relating to your treatment, payment and our healthcare operations. Your personal health information will never be otherwise given to anyone even family members without your written consent. You, of course may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of you records is always protected. Our privacy policies and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

***Collecting Protected Health Information***

We will only request personal information needed to provide our standard of quality healthcare, implement payment activities, conduct normal health practice operations and apply with law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most information will be collected from you, we obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

***Disclosure of your Protected Health Information***

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your consent. We may use and/or disclose your health information to communicate reminders about your appointments including voice mail messages, answering machines and postcards.

***Patient Rights***

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

I GRANT ACCESS TO MY PERSONAL HEALTH INFORMATION TO THE FOLLOWING:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME RELATIONSHIP TO PATIENT

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME RELATIONSHIP TO PATIENT

**IDENTITY THEFT: DUE TO IDENTITY THEFT YOU AGREE TO SHOW YOUR ID EVERYTIME YOU MAY COME TO THE OFFICE. ANYONE ASSIGNED ABOVE MUST ALSO PRESENT A PHOTO ID.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT OR PERSONAL REPRESNTATIVE DATE

**­­HIPPA INFORMATION**

*I prefer that you call me at: [ ] Home [ ] Work [ ] Cell*

*I authorize this practice to leave messages regarding my medical appointments, conditions, test results, with:*

Household Family Members [ ] Yes [ ] No Cell Phone [ ] Yes [ ] No

Answering Machine Home [ ] Yes [ ] No Answering Machine Work [ ] Yes [ ] No

Arlington ENT Associates, P.C.

***FINANCIAL POLICIES***

I authorize payment of medical benefits to ARLINGTON ENT ASSOCIATES, P.C for services provided.

**ARLINGTON ENT ASSOCIATES, P.C., will charge my account a $10 processing fee for replacing lost** **prescriptions or orders**. I understand that I will be given a prescription for any medications I require during my appointment at no charge. I also understand that the charge of $10 only pertains to requests for additional processing of prescription given faxing or called in RX.

**ARLINGTON ENT ASSOCIATES, P.C., will charge my account a $50 no-show fee** if I do not call to cancel my appointment at least 24 hours before my scheduled appointment time**. $75** will be charged for VNG and Allergy Testing cancellations. **$150 will be charged for surgery cancellation and $ 75 for rescheduling of surgery.**

**ARLINGTON ENT ASSOCIATES, P.C., will charge my account a $10 fee** in addition to my copay amount if I do not pay my copay at the time of my appointment.

**ARLINGTON ENT ASSOCIATES, P.C., will charge my account a $40 returned check fee** for any check which is returned for any reason and will not be able to write another check for payment.

**ARLINGTON ENT ASSOCIATES, P.C., will charge my account a $10 fee and $.50 per page** for medical records any letters requested to any of the physicians a fee will be involved ranging from **$50 to $ 75.**

I understand that it is my responsibility to provide the office of ARLINGTON ENT ASSOCIATES, P.C, a **referral** along with **my current insurance card** at the time services are rendered to me. I understand that if I provide incorrect or expired insurance information I will assume **full financial responsibility for all charge incurred.**

I agree to pay in full any balance for services that are deemed to be my responsibility; this may include services denied by my insurance as non-covered, applied to my deductible, part of my coinsurance, etc. Should the account be referred to an attorney for collection, the undersigned shall pay attorney, fees and collection expenses. All delinquent accounts will be assessed interest at the legal rate. It is understood that bills are payable upon presentation.

***Notice of Disclosure of Ownership Interest***

|  |
| --- |
| Arlington ENT Associates, P.C. (Arlington ENT) is wholly owned by a subset of the physicians who provide care in the office of Arlington ENT. The Same group of physician owners also owns a separate entity, Arlington Audiology Associates, LLC., the hearing aid center. Because of the physicians’ ownership, they are best able to ensure the highest level of care is provided to you from both entities mentioned above.  A schedule of fees related to the services you might receive can be provided at your request. You have the right to request that services be provided at locations other than that described above. |

*I have reviewed ARLINGTON ENT ASSOCIATES, P.C Notice of Privacy Practices and Financial Policy and I am acknowledging this Notice of Disclosure of Ownership Interest on the date set forth below.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Patient’s Printed Name Date

PATIENT ACCOUNT # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(FOR OFFICE USE ONLY)**

ARLINGTON ENT ASSOCIATES, PC.

1635 N. GEORGE MASON DR. SUITE 250, ARLINGTON, VA 22205

703-524-1212

**MEDICAL HISTORY FORM**

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHIEF COMPAINT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PAST MEDICAT HISTORY:

[ ] High Blood Pressure [ ] Diabetes [ ] Asthma [ ] Hepatitis

[ ] High Cholesterol [ ] Thyroid Problems [ ] Stroke [ ] Kidney Problems

[ ] Heart Disease [ ] Ulcer [ ] TIA [ ] Gastroesophageal Reflux

[ ] Heart Attack [ ] Bleeding Problems [ ] Seizures [ ] Allergies

[ ] Cancer (What Type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Prior Surgeries**: [ ]Yes [ ] No. If yes, please list surgeries and dates:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you ever experienced problems with **anesthesia**? [ ]No [ ]Yes. If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any environmental allergies or sensitivities to pollen, dust, food, bees, etc? [ ] No [ ] Yes. If yes, please indicate what you are allergic to and the reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you **ALLERGIC** to any medication ? [ ] No [ ] Yes. If yes, please list below

NAME OF MEDICATION ADVERSE REACTION

Please list ANY prescription, over-the-counter medication, and herbal medicine you are taking currently

MEDICATION DOSAGE FREQUENCY PROBLEM BEING TREATED

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL AND PERSONAL HISTORY**

Marital Status [ ] Single [ ] Married [ ] Divorces [ ] Widowed

What is your occupation? Check here if Retired [ ]

Do you or have you ever used tobacco of any form? [ ] No [ ] Yes. If yes, list amount and duration:

Do you or have you ever used alcohol? [ ] No [ ] Yes. If yes, list amount and duration (drinks per day or drinks per week):

**FAMILY MEDICAL HISTORY**

[ ] Allergies [ ] Asthma [ ] Bleeding disorder [ ] Hearing Loss

[ ] Cancer (List type of cancer and family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**REVIEW OF SYMPTOMS**

**Please indicate whether you have had any of the symptoms or conditions listed below:**

**GENERAL RESPIRATORY ENDOCRINE**

Unintentional weight gain [ ] Cough [ ] Thyroid problems [ ]

Unintentional weight loss [ ] Wheezing [ ] Heat intolerance [ ]

Fever [ ] Shortness of breath [ ] Cold intolerance [ ]

Tiredness [ ] Coughing blood [ ] Excessive thirst [ ]

Night sweats [ ]

**EYES CARDIAC URINARY**

Loss of vision [ ] Chest pain [ ] Difficulty urinating [ ]

Double vision [ ] Palpitations [ ] Frequent urination [ ]

Eye pain [ ] Irregular heartbeat [ ] Painful urination [ ]

Tearing [ ] Swelling of legs [ ] Blood in urine [ ]

**ENT GASTROINTESTINAL NEUROLOGIC**

Ear pain [ ] Heartburn [ ] Headaches [ ]

Ringing or sounds in the ear [ ] Nausea [ ] Blackout [ ]

Hearing loss [ ] Vomiting [ ] Seizures [ ]

Ear discharge [ ]Diarrhea [ ] Paralysis or muscle weakness [ ]

Itchy ears [ ] Constipation [ ] Tremors [ ]

Dizziness [ ] Blood in stool [ ] Numbness or loss of sensation [ ]

Nosebleed [ ]

Nasal congestion [ ] **BLOOD & LYMPHATIC**

Nasal discharge [ ] Easy bruising or bleeding [ ]

Loss of smell [ ] Swollen lymph nodes[ ]

Loss of taste [ ]

Lesion in mouth [ ]

Sore throat [ ]

Difficulty swallowing [ ]

Hoarse voice [ ]

*I certify that the information provided in this questionnaire is correct and complete to the best of my knowledge. Further, I understand that providing incorrect or incomplete medical information may not only jeopardize my health but also render ineffective or even harmful any treatments provided to me.*

Patient or consenting adult signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_