PATIENT MEDICAL HISTORY

Patient Name:_____ Date:_____
Age:_____Height:_____ Weight:_____
Referring M.D _____ Primary M.D._____

Reason for today's visit:_____
Duration of problem:# of Days_____ #Weeks_____#Months_____ #Years_____
Please Circle Duration of Problem: Constant Intermittent Episodic Rare
Please Circle Severity of Problem: Mild Moderate Severe Intolerable
What Makes it Better or Worse:_____

Are you (patient) ALLERGIC to any Medications? Please Circle YES NO. If yes, please list below the medication(s) and reaction:

_____
_____
_____

List the medications you (patient) are currently taking and dosage:

_____
_____
_____

Review of Symptoms: (Please CIRCLE all that applies)

Constitutional Symptoms: fatigue weight loss fevers chills nausea headaches other
Ears: pain drainage hearing loss ear ringing vertigo hearing aids itching other
Nose: sinus pain nasal drainage congestion bleeding polyps decreased smell other
Eyes: double vision glaucoma cataracts blindness blurred vision other
Throat: pain hoarseness swallowing difficulty other
Skin: melanoma basal cell cancer other lesions or conditions
Allergic: nasal allergies itchy eyes sneezing fits previous allergy testing other
Heart and Circulation: angina irregular heartbeat congestive heart failure leg swelling other
Cancer: lung prostate breast head and neck colon cervical other
Lungs: cancer asthma shortness of breath wheezing cough emphysema other
Digestive System: gastric reflux ulcers diarrhea bloody stool vomiting constipation other
Endocrine: non-insulin diabetes hypothyroid hyperthyroid other
Blood & Lymphatic: anemia bleeding disorder enlarged lymph nodes other
Genitourinary: bloody urine incontinence bladder cancer prostate cancer other
Musculoskeletal: muscle pain muscle weakness osteoporosis other
Neurologic: stroke seizures weakness dizziness memory loss headaches other
Psychiatric: alcoholism drug addiction depression other
Reproductive: (if applicable) Pregnant?____ # of children____hysterectomy_____ cervical cancer____
Other conditions not mentioned:_____

SOCIAL HISTORY

Do you smoke now? _____ If so, how much?_____ How many Years?_____
Have you ever smoked?_____ How much?_____ How many years?_____ Year stopped?_____
Do you drink alcohol?_____ How much?_____ Do you drink every day?_____
What is/was your occupation? (if applicable)_____

FAMILY HISTORY

Do any of your close relatives have any of these conditions?
Bleeding Disorders?_____ Reactions to anesthesia?_____ Drug Reactions?_____
Fever with anesthesia?_____ Hereditary Disease?_____
If yes, please
explain:_____
_____
_____

SURGICAL HISTORY

List all surgeries by date and complications (if any):

_____
_____
_____

ADDITIONAL INFORMATION

Please list any recent blood work, x-rays, CT scans, MRIs, swallowing studies, audiograms or important information that we need to know for your visit today and location where testing was done:

_____
_____
_____

The above information was reviewed with the patient:

_____
MD Signature Date:

PATIENT REGISTRATION FORM

Patient Name:_____

Local Address:_____

City:_____State:_____Zip Code:_____

Home #:_____Cell #:_____ Work #:_____

Please Circle: Male / Female Age:_____ Birthdate:_____Soc Sec #:____-____-_____

Email:_____ Employer:_____

Pharmacy:_____ Pharmacy Ph #:_____

Out of State Address:_____ City:_____

State:_____ Zip Code:_____ Out of State Ph #:_____

If Patient is a Minor:
Mother's Name:_____ Date of Birth:_____ S.S.#:_____
Father's Name:_____ Date of Birth:_____ S.S.#:_____

INSURANCE INFORMATION

Primary Policy Holder's Name:_____
Primary Policy Holder's Date of Birth:_____ Primary Policy Holder's S.S.#_____

Secondary Policy Holder's Name:_____
Secondary Policy Holder's Date of Birth:_____ Secondary Policy Holder's S.S.#_____

Signature of Patient:_____ Date:_____
Guardian's Signature (if minor)_____ Date:_____
Guardian's Name (please print):_____
Relationship to Patient:_____

Shea ENT Clinic and Physician's Hearing Clinic

HIPAA - Patient Consent of Information

Shea ENT Clinic & Physician's Hearing Clinic, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Shea ENT Clinic and Physician's Hearing Clinic from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Shea ENT Clinic and Physician's Hearing Clinic physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Shea ENT Clinic and Physician's Hearing Clinic physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

_____ via text message
_____ on an answering machine or voicemail at home or cell phone
_____ on an answering machine or voicemail at work
_____ with_____relationship_____
_____ with_____relationship_____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

HIPAA – Notice of Privacy Practice Acknowledgement

_____I have been provided a copy of Shea ENT & PHC Practice.

_____I have declined a copy of Shea ENT & PHC Notice of Privacy Practice.

_____ _____
Patient's Signature Date