NorthWest ENT&Allergy

Please tell us why you are here today:_____

Please list any allergies (drugs, foods, seasonal):

_____

Please list current medications (Blood thinners, Antibiotics, Steroids, other):_____

_____

PAST MEDICAL HISTORY:

Blood Disorders: ☐ **None**

☐ Anemia ☐ Blood Clots

☐ Deep Vein Thrombosis ☐ Other:_____

Cancer: ☐**None**

What kind?_____

Where is/was it located?_____

Endocrine: ☐**None**

☐ Diabetes ☐ Hypothyroidism

☐ Hyperthyroidism

☐ Other:_____

Digestive: ☐**None**

☐ Gallstones ☐ Reflux/ Heartburn

☐ Intestinal Problems ☐ Hepatitis

Other:_____

Neurological Disorders: ☐ **None**

☐ Dementia/Memory ☐ Stroke / TIA

☐ Parkinson's ☐ Epilepsy

☐ Other:_____

Heart Disease: ☐ **None**

☐ Angina / Chest Pain / Heart attacks

☐ Arrhythmias ☐ High Blood Pressure

☐ Pacemaker ☐ Other:_____

Allergy / Rheumatology: ☐ **None**

☐ Arthritis ☐ Sjogren's Disease

☐ Severe Allergic Reaction:_____

Respiratory / Lung: ☐ **None**

☐ Asthma ☐ Emphysema

☐ Other:_____

Integumentary / Skin: ☐ **None**

☐ Eczema ☐ Psoriasis

☐ Other:_____

Urinary: ☐ **None**

☐ Bladder:_____

☐ Kidney:_____

☐ Other: _____

PAST Surgical History: ☐ None

☐ Ear surgery ☐ Ear Vent Tubes ☐ Gallstones ☐ Gallbladder Removal

☐ Hernia ☐ Heart Surgery ☐Lung / Airway Surgery

☐ Septoplasty ☐ Sinus Surgery ☐ Tonsillectomy / Adenoidectomy

☐ Other:_____

Have you ever had any complications with anesthesia?_____

If yes, please explain_____

NorthWest ENT&Allergy

Adult Social History (For patients 18 years of age and older):

Tobacco use? ☐ Yes ☐ No ☐ Quit How many years of tobacco use?_____

Alcohol use? ☐ Yes ☐ No ☐ Quit Caffeine intake? ☐ Yes ☐ No

Illicit drug use? ☐ Yes ☐ No ☐ Quit Number of children? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced Occupation:_____

Family History:

Mother ☐ Living ☐ Deceased Health problems:_____

Father ☐ Living ☐ Deceased Health problems:_____

Siblings ☐ Living ☐ Deceased Health problems:_____

Adopted ☐ Yes ☐ No

CURRENT PROBLEMS (Last 6 months):

Constitutional: ☐ **None**

☐ Fever ☐ Weight loss___lbs

☐ Fatigue ☐ Weight gain___lbs

☐ Other:_____

Ears: ☐ **None**

☐ Hearing Loss ☐ Ringing

☐ Pressure ☐ Pain

☐ Pain ☐ Discharge

☐ Dizziness / Vertigo Other:_____

Eyes: ☐ **None**

☐ Blurred vision ☐ Burning

☐ Double vision ☐ Itching

☐ Eye pain

☐ Other:_____

Nose: ☐ **None**

☐ Nosebleeds ☐ Obstruction

☐ Sinus pressure ☐ Runny nose

☐ Congestion ☐ Other:_____

Mouth / Throat: ☐ **None**

☐ Sore throat ☐ Mouth ulcers

☐ Bleeding gums ☐ Difficulty swallowing

☐ Dry mouth ☐ Postnasal drip

☐ Oral abnormalities ☐ Hoarseness

☐ Other:_____

Neurologic: ☐ **None**

☐ Fainting ☐ Headache

☐ Weakness ☐ Seizures

☐ Numbness ☐ Dizziness

☐ Other:_____

Cardiovascular: ☐ **None**

☐ Chest pain ☐ Murmur

☐ Palpitations ☐ Leg swelling

☐ Other:_____

Respiratory / Lungs: ☐ **None**

☐ Cough ☐ Wheezing

☐ Snoring ☐ Shortness of breath

☐ Other:_____

Digestive: ☐ **None**

☐ Heartburn ☐ Nausea / vomiting

☐ No appetite ☐ Increased appetite

☐ Other:_____

Skin / Muscles: ☐ **None**

☐ Rash ☐ Lump

☐ Muscle Pain ☐ Bruise easily

☐ Other:_____

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have been given a copy of Northwest ENT & Allergy's Notice of Privacy Practices. This notice describes how Northwest ENT & Allergy may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my health information.

Signature of Patient or Guardian:

X: _____ Date: ____/____/_____

Consent to Release Health Information:

I understand that Northwest ENT & Allergy will use, disclose, store and maintain health information about me. I understand that my health information may include information that is created or received by Northwest ENT & Allergy, may be in the form of written records, electronic records, or spoken words and may include information about my health history, health status, symptoms, exams, test results, diagnosis, treatment, procedures, prescriptions, and similar types of health-related information.

Signature of Patient or Guardian:

X: _____ Date: ____/____/_____

Who can we talk to about your healthcare?:

Name:_____ Relationship:_____Phone#:_____

Name:_____ Relationship:_____Phone#:_____

Signature of Patient or Guardian:

X: _____ Date: ____/____/_____

Are there any specific practices you would like us to talk to about your healthcare? Please list their full name:_____

_____

Acknowledgement of No-Show & Cancellation Policy:

A patient is considered a "No-Show"if they cancel within 24 hours of their appointment, or fail to show-up, or arrive 15 minutes after their scheduled arrival time. If you No-show 3 times, we will not be able to put you back onto the schedule.

Signature of Patient or Guardian:

X: _____ Date: ____/____/_____

Financial Agreement

I am responsible for the full amount of my copayment and/or deductible payment at the time of service as determined by my insurance carrier, health plan or government program. Northwest ENT and Allergy will file an insurance claim on my behalf. I am responsible for the full payment of any outstanding balance. A $50.00 charge will be added for all returned checks.

If uninsured, payment will be due in full at the time of service.

I am responsible for any outstanding balance. If I default on my balance, I am responsible for all collection costs and attorney fees.

Signature of Patient or Guardian:

X:_____Date:____/____/_____