

GREENSBORO EAR, NOSE & THROAT ASSOCIATES. P.A

NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____ **DATE OF VISIT:** _____

YOUR REGULAR DOCTOR _____ **REFERRING DOCTOR** _____ **MARITAL STATUS** _____

What symptoms brought you here? _____ How long has this been bothering you? _____

Do you consume Alcohol? Yes No If Yes What kind and How Much _____

Have you ever used tobacco products? Yes No If Yes What kind and How Much _____

Do you use tobacco products now? Yes No If Yes What kind and How Much _____ If No- When did you quit? _____

Has your weight changed during the past year? Yes No If Yes Pounds Gained _____ Pounds Lost _____

Please list any operations you have had and the approximate year you had them.

Please list any medications you are taking.

Please list any medications you are allergic to.

Name of Medicine How much each day?

Name of Medicine Reaction

Have you or anyone in your immediate family had any of these problems? Please Circle Yes or No

If you answer yes please explain (yourself or relative e.g. mother, son, uncle)

Asthma	Yes	No		Epilepsy	Yes	No		Lung Disease	Yes	No	
Allergies	Yes	No		Heart Burn	Yes	No		Liver Disease	Yes	No	
Bleeding Disorders	Yes	No		High Blood Pressure	Yes	No		Strokes	Yes	No	
Cancer	Yes	No		High Fevers	Yes	No		Sugar Diabetes	Yes	No	
Chest Pain	Yes	No		HIV	Yes	No		Tuberculosis	Yes	No	
Heart Attack	Yes	No		Hepatitis	Yes	No		Problems w/Anesthesia	Yes	No	
Emotional	Yes	No		Syphilis	Yes	No		Indigestion	Yes	No	
Mental	Yes	No		Venereal Disease	Yes	No		Hearing Loss	Yes	No	

Have you had any recent symptoms related to the following body systems?

General (e.g. general health, fever, chills, sweats) _____ Eyes (e.g. vision changes, double or blurry vision) _____

Cardiovascular (e.g. chest pain, palpitations, fainting) _____ Respiratory (e.g. shortness of breath, cough, pneumonia) _____

Gastrointestinal (e.g. nausea, vomiting, swallowing) _____ Genitourinary (e.g. kidney stones, pain with urination) _____

Musculoskeletal (e.g. joint pain, muscle weakness, swelling) _____ Skin (e.g. rash, skin lesion, sores, bruising) _____

Neurological (e.g. weakness, numbness) _____ Psychiatric (e.g. depression anxiety) _____

Endocrine (e.g. dry skin, cold or hot intolerance) _____

PERMISSION TO DISCUSS MEDICAL NEEDS

Patient Name _____ Date of Birth _____

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient, or leave information on an automated answering machine.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name of Patient, Parent or Guardian

Signature

Date

For Office Use Only

*We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledge could not be obtained because:*

- Individual refused to sign*
- Communications barriers prohibited obtaining the acknowledgment*
- Other (Please Specify) _____*