# ENT Associates of San Diego

## Personal Information

Today's Date: ____________ Account #: ____________ SSN: ____________

First Name: ____________ MI: ______ Last Name: ____________

Address: ________________________________

Zip Code: ________ City: ____________ State: ____________

Date of Birth: ____________ Age: ______ Marital Status: ____________

Sex: ________ May we leave information on your answering machine or voicemail? ☐ Yes ☐ No

Primary Phone: (number you wish to be reached at) ____________ Other #: ____________

Occupation: ____________________ Work No: ____________

Employer: ____________________ Full Time Student: ☐ Yes ☐ No

**In the event of an emergency please contact:**

Name: ____________ Relationship: ________ Phone No: ____________

Minor Patients: Name of Parent/Guardian ____________________

Who Referred you? ☐Physician ☐Family ☐Friend ☐Phone Book ☐Insurance Co. ☐Other ________

Referring Physician's Name: ____________________ Phone No: ____________

Primary Care Physician's Name: ____________________ Phone No: ____________

## Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: ____________________ Insured's Name: ____________

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: ____________ Group#: ____________

Employer: ____________ SSN: ____________ DOB: ____________

Secondary Insurance: ____________________ Insured's Name: ____________

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: ____________ Group #: ____________

Employer: ____________ SSN: ____________ DOB: ____________

**NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:**

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

**I have read the above information and understand that I am responsible for payment for services I receive.**

**Patient/Guardian Signature:** ____________________ **Date:** ____________

# ENT PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** This information will be entered into your electronic medical record. You are welcome to a copy of the report if you wish.

**Full Name** ____________________________________________ **Male** ☐ **Female** ☐ **Could you be pregnant?** ☐ **Yes** ☐ **No**

**E-mail address** | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ |

**Pharmacy Preference (include location)** __________________________________________ **Preferred Language** _______________

**Family Physician** ________________________________________ **Referring Physician** ___________________________________

**Optional - Please check the correct answers**

**Race:** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Native Hawaiian/Other Pacific Islander ☐ White

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**CURRENT MEDICATIONS: Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)** ☐ **Yes** ☐ **No**

| Name of Medication (Prescribed, Over-the-Counter, or Herbal) | Name of Medication (Prescribed, Over-the-Counter, or Herbal) |
| --- | --- |
| | |
| | |
| | |
| | |
| | |

**MEDICATION ALLERGIES: Are you ALLERGIC to ANY MEDICATIONS?** ☐ **Yes** ☐ **No**
**If YES, please list below.**

| Name of Medication | Type of Reaction |
| --- | --- |
| | |
| | |
| | |

**NON-MEDICATION ALLERGIES:**
**Are you allergic to anything in the environment such as pollens, dust, food, etc.?** ☐ **Yes** ☐ **No**
**If YES, please indicate what you are allergic to.** ____________________________________________________________
**Have you ever had an allergy test?** ☐ **Yes** ☐ **No** **If YES check: Skin____ or Blood _____**

**PAST HEALTH HISTORY: Have you ever been *DIAGNOSED* with any of the following problems?**

**Cancer :** ☐ Yes ☐ No
What type/year________________________________

**Eyes:**
Glaucoma ☐ Yes ☐ No

**Ears:**
Hearing Loss ☐ Yes ☐ No

**Nose and Sinus:**
Nasal Allergies ☐ Yes ☐ No
Nasal Polyps ☐ Yes ☐ No
Recurrent Sinusitis ☐ Yes ☐ No

**Mouth and Throat:**
Recurrent Tonsillitis ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
TMJ ☐ Yes ☐ No

**Heart and Blood Vessels:**
Stroke (Cerebral Vascular) ☐ Yes ☐ No
High / Elevated Cholesterol ☐ Yes ☐ No
Heart Attack ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No

**Lungs and Respiratory:**
Asthma ☐ Yes ☐ No
Chronic Obstructive Pulmonary Disease (Emphysema/COPD) ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No

**Stomach and Digestive:**
Barrett's Esophagus ☐ Yes ☐ No
Gastrointestinal Reflux ☐ Yes ☐ No
H. Pylori Infection ☐ Yes ☐ No
Hepatitis (Type _______) ☐ Yes ☐ No
Hiatal Hernia ☐ Yes ☐ No
Irritable Bowel Syndrome ☐ Yes ☐ No
Stomach Ulcer ☐ Yes ☐ No

**Kidney and Gender:**
Renal Failure ☐ Yes ☐ No

**Mental & Emotional:**
Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No

**Glands, Hormones, and Sugar Control:**
Diabetes ☐ Yes ☐ No
Thyroid Dysfunction ☐ Yes ☐ No

**Blood & Lymph Nodes:**
Anemia ☐ Yes ☐ No

**Immune/Autoimmune & Infectious:**
AIDS ☐ Yes ☐ No
HIV Positive (has not developed AIDS) ☐ Yes ☐ No
Infectious Mononucleosis ☐ Yes ☐ No

**CONTINUED ON BACK**

## SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **Yes** ☐ **No**

**If YES, please list what sort of problems.** ____________________

Have you ever had ear, nose or throat surgery? ☐ **Yes** ☐ **No**

**If YES, list any surgeries and when they were done.** ____________________

Have you ever had any major surgeries before? ☐ **Yes** ☐ **No**

**If YES, list the type and year.** ____________________

Have you been hospitalized for a medical problem before? ☐ **Yes** ☐ **No**

**If YES, list hospitalizations, the reason for admission and the date.** ____________________

## FAMILY HISTORY:

**Specific Anesthesia Problem** ☐father ☐mother ☐brother ☐sister

**Ears:**

Hearing Loss before age 20 ☐father ☐mother ☐brother ☐sister

Hearing Loss before age 50 ☐father ☐mother ☐brother ☐sister

**Nose and Sinus:**

Nasal Allergies ☐father ☐mother ☐brother ☐sister

**Heart and Blood Vessels:**

Heart Disease ☐father ☐mother ☐brother ☐sister

High Blood Pressure ☐father ☐mother ☐brother ☐sister

**Lungs and Respiratory:**

Asthma ☐father ☐mother ☐brother ☐sister

Lung Cancer ☐father ☐mother ☐brother ☐sister

**Brain and Nervous:**

Stroke ☐father ☐mother ☐brother ☐sister

**Blood & Lymph Node:**

Bleeding/clotting problem ☐father ☐mother ☐brother ☐sister

**Other** _______________ ☐father ☐mother ☐brother ☐sister

## SOCIAL HISTORY:

What is or was your occupation? ____________________ ☐ Check here if you are retired.

Have you ever used tobacco in any form? ☐ **Yes** ☐ **No**

**If yes, have you quit?** ☐ **Yes** ☐ **No**

**Please complete the following:**

| Type of Tobacco | Start Year | Quit Year |
|---|---|---|
| Cigarettes per day: ________ | | |
| Other: (list type) __________ | | |

Do you consume alcohol? ☐ **Yes** ☐ **No**

**If YES, please complete the following:**

| Type of Alcohol | How Much? | How Often? |
|---|---|---|
| | | |
| | | |

Are you exposed to second hand smoke? ☐ **Yes** ☐ **No**

Do you use drugs recreationally? ☐ **Yes** ☐ **No** **If YES, please list**____________________

## REVIEW OF SYSTEMS: **Mark yes or no and check any *SYMPTOMS* you have recently experienced:**

**General Health:** ☐ **Yes** ☐ **No**
☐ fever, ☐ sleeping problems, ☐ unintentional weight loss

**Eyes:** ☐ **Yes** ☐ **No**
☐ double vision, ☐ itchy eyes

**Ears:** ☐ **Yes** ☐ **No**
☐dizziness, ☐ drainage, ☐ hearing loss, ☐ pain, ☐ringing

**Nose & Sinus:** ☐ **Yes** ☐ **No**
☐ nasal congestion, ☐ inflammation, ☐ post-nasal drainage

**Mouth & Throat:** ☐ **Yes** ☐ **No**
☐ hoarseness or change in voice, ☐ snoring, ☐ sore throat, ☐ ulcers

**Heart or Circulation:** ☐ **Yes** ☐ **No**
☐ blacking out or fainting, ☐ bluish discoloration of lips or fingernails, ☐ chest pain, ☐ irregular heartbeat, ☐ leg cramps, ☐ swelling (including ankles)

**Lung or Respiratory:** ☐ **Yes** ☐ **No**
☐ frequent non-productive cough, ☐frequent productive cough, ☐shortness of breath, ☐ wheezing

**Stomach:** ☐ **Yes** ☐ **No**
☐abdominal pain, ☐diarrhea, ☐heartburn or indigestion, ☐ nausea, ☐vomiting

**Musculoskeletal:** ☐ **Yes** ☐ **No**
☐ pain in neck

**Skin or Breast:** ☐ **Yes** ☐ **No**
☐ breast masses or lumps, ☐ skin pain

**Brain or Nervous System:** ☐ **Yes** ☐ **No**
☐ headache, ☐ numbness (loss of sensation), ☐ severe face pain, ☐ seizures, ☐ weakness

**Mental and Emotional:** ☐ **Yes** ☐ **No**
☐ feel nervous (anxiety),☐ feel sad more than usual (depressed), ☐ suicidal thoughts

**Glands and Hormones:** ☐ **Yes** ☐ **No**
☐ increased appetite, ☐ fatigue (excessive), ☐feel hot when others do not ☐ feel cold , ☐ neck has enlarged ☐ weight change (unwanted or unexpected)

**Blood or Lymph Nodes:** ☐ **Yes** ☐ **No**
☐bleeds excessively after injury, ☐bruises easily ☐masses (lumps) in neck

**Allergies:** ☐ **Yes** ☐ **No**
☐food intolerance, ☐hives, ☐severe reaction to insect bites, ☐ frequent sneezing

**Patient Name ______________________________**

## The Federal Government requires us to ask our patients the following questions. We appreciate your cooperation.

**FEMALE PATIENTS ONLY (BETWEEN THE AGES OF 40 AND 69):**

**Have you had a mammogram within the last 2 years?** ☐ Yes ☐ No

**Have you had a mastectomy?** ☐ Yes ☐ No

**FOR PATIENTS 50 YEARS OF AGE AND OLDER:**

**Have you had a FLU shot in the past 12 months?** ☐ Yes ☐ No

**FOR PATIENTS AGES 50 THROUGH 75:**

Colorectal Cancer Screening

**Have you had a colonoscopy in the past 10 years?** ☐ Yes ☐ No

**Have you had a fecal occult blood test this year?** ☐ Yes ☐ No

**Have you had a flexible sigmoidoscopy in the past 5 years?** ☐ Yes ☐ No

**Do you have a history of colon cancer?** ☐ Yes ☐ No

**FOR PATIENTS 65 YEARS OF AGE AND OLDER:**

**Have you had a PNEUMONIA shot?** ☐ Yes ☐ No

**If yes, what year? ____________________**

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**Please complete this form if you are 60 years of age or older.**

## Fall Prevention Balance and Dizziness Survey

**Patient Name:** ______________________________ **Age:** __________ **Date:** ____________________

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer "yes" to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she can help determine the cause of your symptoms.

| Please read each question and check the box that best describes your answer | Yes or Often | Sometimes | No or Never |
|---|---|---|---|
| 1. Do you ever lose your balance or feel dizzy or unsteady? | | | |
| 2. Have you continued to experience dizziness after an injury or accident? | | | |
| 3. Do you feel unsteady when you are walking or climbing stairs? | | | |
| 4. Do you feel dizzy while sitting down or rising from a seated or lying position? | | | |
| 5. Does walking down the aisle of a supermarket or stopping next to moving traffic make you feel dizzy? | | | |
| 6. Does moving your head quickly make you dizzy or cause you to feel nauseous? | | | |
| 7. Are you dizzy or unsteady when you first get up in the morning? | | | |
| 8. Do you ever fall or feel like you are about to fall for no apparent reason? | | | |
| 9. Do you use a walker, cane, or any other form of assistance for your mobility? | | | |
| 10. Have you had a recent loss of, or decrease in, your vision or hearing? | | | |
| 11. Do you fear falling? | | | |
| 12. Have you experienced dizziness, vertigo, or serious imbalance in the past 6 months? | | | |
| 13. Has your balance problem caused problems in your social life? | | | |
| 14. Have you fallen more than once in the past year without an obvious cause? | | | |
| 15. Does dizziness or imbalance interfere with your job or your household responsibilities? | | | |

***Please return this form to the doctor or staff during your visit.***