

Nashville ENT New Patient Form

All information is strictly confidential and will be released only with our written permission.

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: _____

Referring Physician: _____ Phone: _____

What is your reason for today's visit? _____

1. When did this problem start? _____
2. What makes this problem worse/better? _____
3. Where is the problem located? _____
4. What other symptoms are associated with this problem? _____
5. What medications have you taken for this problem? _____

PAST HISTORY

List current medications: _____

List medical problems (such as diabetes, heart disease, blood pressure, etc.): _____

List past surgeries: _____

List drug allergies: _____

ROS: Are you currently having any of the following? (please circle)

Fevers?	Y	N	Weight Change?	Y	N
Skin Rash?	Y	N	Headache?	Y	N
Chest Pain?	Y	N	Shortness of breath?	Y	N
Nausea/vomiting?	Y	N	Leg cramps?	Y	N
Muscle/joint pain?	Y	N	Weakness/numbness in arms?	Y	N
Easy Bleeding?	Y	N	Heat/Cold intolerance?	Y	N
Mood Disturbance?	Y	N	Urinary Problems?	Y	N

SOCIAL AND FAMILY HISTORY

Do you smoke? Y N If yes, how much? _____ How long? _____

Do you drink alcohol? Y N If yes, how much? _____

Occupation? _____

Have you ever had a blood transfusion? _____ Marital Status? _____

Has anyone in your family had:

Diabetes?	Y	N	Strokes?	Y	N
Heart Problems?	Y	N	Cancer?	Y	N
Bleeding Problems?	Y	N	Kidney Disease?	Y	N
Seizures?	Y	N	Tuberculosis?	Y	N