Physicians

EAR, NOSE & THROAT

Patient Intake Form

Patient Information

Name:	DOB:	Age:	Sex:
Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	E-mail:
Occupation:	Employer:	Work Phone:

Emergency Contact:	Relationship:	Phone:

Primary Care Provider:		Practice Location:
Referring Provider:		Practice Location:
Additional Specialist:	Specialty:	Practice Location:
Additional Specialist:	Specialty:	Practice Location:
Additional Specialist:	Specialty:	Practice Location:

Preferred Pharmacy:	Address:	Phone:

Insurance Information

Primary Insurance	Policy #:	Group #:
Policy Holder Name:	Policy Holder DOB:	Relationship to Patient:
Secondary Insurance	Policy #:	Group #:
Policy Holder Name:	Policy Holder DOB:	Relationship to Patient:

Physicians

EAR, NOSE & THROAT

Patient Intake Form

History of Present Illness

What is the primary problem or symptom you wish to have addressed today?

What treatment(s) have you had for this problem? ☐ N/A

- ☐ **Antibiotics** — **# of antibiotic courses in past 12 months: _______**
- ☐ **Oral steroids** — **# of oral steroid courses in past 12 months: _______**
- ☐ **Nasal sprays (please list below with approximate duration of use)**
  1. ______________________________ **Duration:** _______________
  2. ______________________________ **Duration:** _______________
  3. ______________________________ **Duration:** _______________
- ☐ **Nasal saline irrigations (please list any medications you have added to irrigations)**

  ____
- ☐ **Nasal or sinus surgery**

  # of previous surgeries:_______

  Dates of previous surgeries: ______________________________________
- ☐ **Antihistamines (i.e. Benadryl, Zyrtec, Claritin, Allegra, Xyzal)**

  Duration: _______________
- ☐ **Other treatments:** ____

Have you had previous allergy testing? ☐ Yes ☐ No

If so, when and where was testing done: ____________________________

Have you taken allergy shots or drops? ☐ Yes, shots ☐ Yes, drops ☐ No

Do you have a history of asthma? ☐ Yes ☐ No

Do you have an allergy to aspirin or NSAIDs (i.e. ibuprofen, naproxen)? ☐ Yes ☐ No

Physicians

EAR, NOSE & THROAT

Patient Intake Form

Past Medical History (check all that apply)	
☐ Allergies ☐ Asthma ☐ Obstructive sleep apnea ☐ Gastroesophageal reflux ☐ Migraines/Headaches ☐ Stroke ☐ Seizure ☐ Neurologic disorder ☐ High blood pressure ☐ High cholesterol ☐ Heart attack ☐ COPD/emphysema ☐ Cystic fibrosis	☐ Diabetes ☐ Kidney disorder ☐ Liver disorder ☐ Hepatitis C ☐ HIV/AIDS ☐ Bleeding disorder ☐ Auto-immune disorder ☐ Depression ☐ Anxiety ☐ Anesthesia complications ☐ Cancer: ____________________ ☐ Other: ____________________ ☐ Other: ____________________
Past Surgical History	
☐ Sinus surgery ☐ Nasal surgery (rhinoplasty) ☐ Septum surgery (septoplasty) ☐ Turbinate surgery (turbinate reduction) ☐ Tonsil removal ☐ Adenoid removal ☐ Palate surgery ☐ Sleep surgery ☐ Facial fracture surgery ☐ Pituitary surgery ☐ Ear tubes	☐ Other ear surgery ☐ Oral surgery ☐ Neck surgery ☐ Heart surgery ☐ Carotid artery surgery ☐ Pacemaker ☐ Neck surgery ☐ Spine surgery ☐ Other: ____________________ ☐ Other: ____________________ ☐ Other: ____________________
Social History	
Tobacco Use ☐ Never smoker ☐ Former smoker, quit date: ___________ ☐ Current smoker, ___ pack/day, ___ years ☐ Smokeless tobacco	Alcohol Use ☐ Daily ☐ Social/occasional ☐ Never/almost never Drug Use: ____________________
Family History	
☐ Bleeding disorder ☐ Problems with anesthesia	☐ Other: ____________________ ☐ Other: ____________________

Physicians

EAR, NOSE & THROAT

Patient Intake Form

Medications (attach copy of medication/allergy list if necessary)	
Drug Name	**Dosing and Frequency**

Medication Allergies	
Drug Name	**Reaction**

Physicians
EAR, NOSE & THROAT

Sino-Nasal Outcome Test

Thank you for taking the time to fill out this questionnaire. This provides valuable information we can use to help tailor a treatment plan specific to you. Please answer each question by marking the most appropriate response based on your symptoms over the past 2 weeks.

Based on how frequently symptoms are experienced and severity of symptoms.	No problem	Very mild problem	Mild problem	Moderate problem	Severe problem	Problem as bad as it can be
1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Cough	0	1	2	3	4	5
5. Post-nasal discharge	0	1	2	3	4	5
6. Thick nasal discharge	0	1	2	3	4	5
7. Ear fullness	0	1	2	3	4	5
8. Dizziness	0	1	2	3	4	5
9. Ear pain	0	1	2	3	4	5
10. Facial pain/pressure	0	1	2	3	4	5
11. Difficulty falling asleep	0	1	2	3	4	5
12. Waking up at night	0	1	2	3	4	5
13. Lack of a good night's sleep	0	1	2	3	4	5
14. Waking up tired	0	1	2	3	4	5
15. Fatigue	0	1	2	3	4	5
16. Reduced productivity	0	1	2	3	4	5
17. Reduced concentration	0	1	2	3	4	5
18. Frustrated/restless/irritable	0	1	2	3	4	5
19. Sad	0	1	2	3	4	5
20. Embarrassed	0	1	2	3	4	5
21. Sense of smell/taste	0	1	2	3	4	5
22. Blockage/congestion of nose	0	1	2	3	4	5
LINE TOTAL						

GRAND TOTAL	