NORTHERN VALLEY ENT

Adult Intake Form

Patient's Name _____ Age _____

Reason for Today's Visit _____

Medications

List Present Medications & Dosage 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Do you take Aspirin/Advil/Tylenol on a regular basis? ☐ Yes ☐ No Vitamins or non prescription meds? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No Please list: _____

Other Allergies (please list): _____

Are you currently pregnant? ☐ Yes ☐ No Are you currently on a contraceptive medication program? ☐ Yes ☐ No

Past Medical History (type & date)

Any & All Hospitalizations 1. _____ 2. _____ 3. _____

Any & All Operations 1. _____ 2. _____ 3. _____

Any & All Illnesses 1. _____ 2. _____ 3. _____

Any & All Injuries 1. _____ 2. _____ 3. _____

Social History

Smoke? ☐ Yes ☐ No _____ packs per day Quit date _____ Caffeine? ☐ Yes ☐ No _____ cups per day

Alcohol? ☐ Yes ☐ No _____ type/amount Diet _____ type

Family History (check any that apply)

☐ Asthma	☐ Diabetes	☐ Tuberculosis	☐ High Blood Pressure	☐ Stroke
☐ Autoimmune Disease	☐ Heart Disease	☐ Headaches	☐ Allergies	☐ Cancer
☐ Thyroid Disease	☐ Bleeding Problems	☐ Problems with Anesthesia	☐ Hearing Loss	

Review of Symptoms (check any that apply)

Ears	☐ Hearing Loss	☐ Tinnitus (noise in ears)	☐ Dizziness (vertigo)
	☐ Pain	☐ Discharge	☐ Hearing Device
	☐ Exposure to Loud Noise	☐ Surgery	
Nose	☐ Difficulty Breathing	☐ Stuffiness	☐ Bleeding
	☐ Change in Smell	☐ Injuries	☐ Nasal Sprays
	☐ Snoring	☐ Surgery	☐ Post-Nasal Drip
Throat	☐ Soreness	☐ Pain or Difficulty Swallowing	☐ Voice Change/Hoarseness
	☐ Tonsillitis	☐ Bad Breath	☐ Bad Taste
	☐ Throat Clearing	☐ Lump	☐ Recent Dental Work
	☐ Surgery		
Neck	☐ Lumps	☐ Thyroid Nodules	☐ Pain
	☐ Injuries	☐ Swollen Glands	☐ Surgery

General

☐ Headaches	☐ Stroke	☐ Paralysis
☐ Loss of Vision	☐ Glaucoma	☐ Eye Disease
☐ Cough	☐ Asthma	☐ Chronic Lung Disease
☐ Tuberculosis	☐ Shortness of Breath	☐ Emphysema
☐ Heart Attack	☐ Angina/Chest Pain	☐ Heart Failure
☐ High Blood Pressure	☐ Arrhythmia (abnormal heartbeats)	☐ Rheumatic Fever
☐ Kidney Disease	☐ Prostate Problems	☐ Kidney Stones
☐ Difficulty Urinating	☐ Vaginitis	☐ Are you pregnant?
☐ Weight Loss or Gain	☐ Heartburn	☐ Reflux
☐ Ulcers	☐ Liver Disease (Hepatitis or Jaundice)	☐ Diarrhea
☐ Constipation	☐ Colitis	☐ Lyme Disease
☐ Diabetes	☐ Psoriasis	☐ Eczema
☐ Rashes	☐ Cancer	☐ Anxiety
☐ Bleeding Problems	☐ Anemia	☐ Easy Bruising

Is there anything else about your medical history that might be helpful for the doctor to know? ☐ Yes ☐ No

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim.

Patient Signature _____Date _____