GREENWICH
EAR, NOSE & THROAT | ALIGN ENT+ Allergy Partner

Patient Intake

Name: ______________________________ DOB: __________ Appointment Date: ______

What is the purpose of today's visit? ______________________________

Have you had any previous workup related to this issue? ______________________________

Have you seen any other medical providers related to this issue? ______________________________

Who is your primary care physician (not group/practice, please)? ______________________________

Did they refer you to us? o Yes o No If no, who did? ______________________________

Who are your other physicians? ______________________________

General Medical Information
Patient's Weight (lbs): ______________ Height: __________

Medical History—Please check if you have or have had any of the following conditions

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clotting
☐ Bronchitis
☐ Cancer
☐ Cataracts
☐ Diabetes
☐ Emphysema
☐ Glaucoma
☐ Hearing Problems
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV Positive
☐ Kidney Disease
☐ Migraine Headaches
☐ Mitral Valve
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Pacemaker
☐ Pneumonia
☐ Prostate Disorder
☐ Psychiatric Disorder
☐ Seizures
☐ Stomach Ulcers
☐ Thyroid Disorder
☐ Tuberculosis

Other Illnesses: ______________________________

____

Current Medical Issues—Please check all that apply

Issue			Issue		
Eyes	☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No
Lungs/Breathing	☐ Yes	☐ No	Numbness/Tingling	☐ Yes	☐ No
Digestion/Stomach Problems	☐ Yes	☐ No	Joint Aches/Pains	☐ Yes	☐ No
Bowel Movements	☐ Yes	☐ No	Depression/Anxiety	☐ Yes	☐ No
Bladder Problems	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Appetite/Weight Change	☐ Yes	☐ No			

Other Current Issues ______________________________

____

Females: Are you currently pregnant? ☐ Yes ☐ No
For Children: Is your child up to date with immunizations? ☐ Yes ☐ No
Do you have a latex allergy? ☐ Yes ☐ No

List ALL ENT-Related Surgeries (include year)

____
____
____

List ALL Other Surgeries (include year)

____
____
____

List ALL Hospitalizations (include year)

____
____
____

List ALL Medications & Doses (include over-the-counter)

____
____
____

List ALL Allergies (drugs, food, environmental):

____
____

Family History—Please check all that apply

☐ Stroke	☐ Heart Disease	☐ Diabetes
☐ Hearing Loss	☐ High Blood Pressure	☐ Cancer
☐ TB	☐ Arthritis	☐ Respiratory Disease
☐ Kidney Disease	☐ Blood Clotting Problems	☐ Other: ______

Social History—Please check all that apply

Tobacco Use:	☐ Yes ☐ No	Usage	☐ < 1 pack/day	☐ 1 pack/day	☐ > 1 pack/day	
Alcohol Consumption:	☐ Yes ☐ No	☐ Daily	☐ 1-2 drinks/week	☐ 1-2 drinks/month	☐ 1-2 drinks/year	
History of Substance Abuse:	☐ Yes ☐ No	If yes, specify: ______				
Recreational Drugs:	☐ Yes ☐ No	If yes, specify: ______				

ENT-Related Symptoms—Please check all that apply

Ears

	Right	Left
☐ Hearing Loss	☐	☐
☐ Noise in Ears	☐	☐
☐ Ear Discharge	☐	☐
☐ Earache	☐	☐

☐ Dizziness
☐ Off-Balance
☐ Loud Noise Exposure
☐ Guns ☐ Job

Nose

☐ Congestion or Stuffiness
☐ Runny Nose
☐ Postnasal Drip
☐ Nosebleeds
☐ Broken Nose
☐ Sinus Infections
☐ Breathing Obstruction
☐ Abnormality of Smell

Throat

☐ Sore Throat
☐ Difficulty Swallowing
☐ Hoarseness
☐ Cough
☐ Mouth Ulcers
☐ Heartburn

Face & Neck

☐ Lump in Neck
☐ Non-Healing Sore
☐ Change in Mole
☐ Scar
☐ Pain