

Today's Date _____

Welcome to our online office. We are anxious to make your visit as convenient as possible. Would you please help us by furnishing the information requested below? This will be used to complete your record and will be kept strictly confidential. Should your address change at any time, please notify our office.

Should you ever need to cancel an appointment, please call and let this office know as soon as possible. If you have any questions about your care, your appointment or our fees, please feel free to discuss them with us.

Patient's Name _____ Age _____ Birth Date _____

Sex: ___M ___F SS# _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Res. Phone _____ **Cell Phone** _____ **Work Phone** _____

Employed by _____ Business Address _____

E-mail Address _____ Pharmacy and Location _____

Primary Physician _____ Referring Physician _____

Chief Complaint _____

Parent or Spouse Information—If patient is a child; please give both parents' information.

Name _____ **Relationship** _____

Address (if not same) _____ SS# _____ Birthday _____

Employer _____ Address _____

Name _____ **Relationship** _____

Address (if not same) _____ SS# _____ Birthday _____

Employer _____ Address _____

(1) Insurance Co. Name/Address _____ **Phone** _____

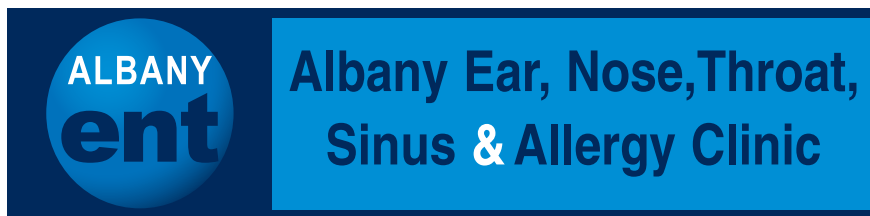
Policy # _____ **Group #** _____ **Policy Holder** _____

(2) Insurance Co. Name/Address _____ **Phone** _____

Policy # _____ **Group #** _____ **Policy Holder** _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Albany ENT or my insurance company to release any information required to process my claims.

Signature _____ **Date** _____



Patient Name _____ Date _____

Review of Systems: Circle items you currently have or have had recently that are related to your visit with us.

General: weight gain weight loss fatigue malaise weakness chills fever night sweats joint pain
stiffness loss of appetite

Eyes: impaired vision blurred vision double vision changes to vision eye pain eye discomfort
redness dryness burning excessive tearing discharge from eye periorbital swelling

Head: headaches vertigo lightheadedness recent head injury

Ears: ear pain hearing loss ringing in ears roaring sound in ears heartbeat noise ear discharge
ear fullness itching in ear ear swelling pressure sensation in the ear

Nose: sinus pain nasal obstruction nasal congestion nose bleeding nasal discharge nasal pain
purulent nasal discharge postnasal drip decreased sense of smell deviated septum snoring

Mouth: bleeding gums dental problems dentures breath odor oral ulcers oral sores oral blisters
oral white spots mouth pain mouth swelling dry mouth

Throat: sore throat frequent throat clearing lump in throat sensation enlarged tonsils hoarseness
change in voice difficulty swallowing

Neck: neck stiffness neck pain neck tenderness thyroid mass neck mass swollen glands
neck swelling

Cardiovascular: chest pain irregular heartbeats rapid heart rate lightheadedness
awakening with air hunger lower extremity edema symptoms upon standing

Respiratory: shortness of breath wheezing cough hoarseness abnormal sputum production
coughing blood

Gastrointestinal: nausea vomiting diarrhea constipation heartburn indigestion excessive belching
retching

Skin: rash itching skin dryness nail changes new skin lesions changes to existing skin lesion lumps
sores changes to moles

Neurological: incoordination tingling or numbness seizures difficulty concentrating
memory difficulties speech difficulties tremors loss of balance blackouts aura

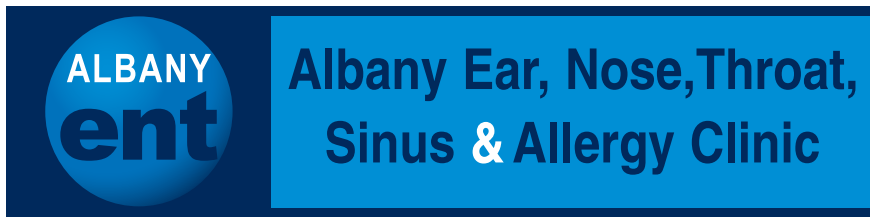
Musculoskeletal: joint pain joint swelling muscle pain limitation of motion muscular weakness
muscle cramp back pain

Endocrine: frequent urination excessive thirst excessive hunger cold intolerance heat intolerance
excessive sweating

Psychiatric: anxiety depression difficulty sleeping irritability

Hematological: lightheadedness easy bleeding easy bruising lymph node enlargement

Allergic: sinus allergy symptoms allergic dermatitis frequent illness



Patient Name _____ Date _____

Past Medical History

List all illnesses, surgeries and injuries

How long? Surgery Date

Present Medications (include over-the-counter, alternative and vitamins)

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Allergies to Medications: None Known

Drug Name	Reaction Type

Family Medical History and who was affected:

Heart Disease _____ Diabetes _____
 Hypertension _____ Lung _____
 Cancer _____ Kidney _____
 Tuberculosis _____ Bleeding Disorder _____

Social History:

Smoking: Never Currently: _____ # packs/day _____ # of years Past: ___ Years Quit
Oral Tobacco: Never Currently: _____ # of years _____ where placed Past: ___ Years Quit
Alcohol: Never Currently: _____ beers/wk _____ liquor/wk _____ wine/wk _____ # of years
Caffeine: Never Currently: _____ coffee/day _____ tea/day _____ soft drinks/day
Other Drugs: Marijuana Cocaine Other _____

For Children: Are they exposed to any type of second hand smoke? _____