New Patient: Ear, Nose, & Throat
3901 South Atherton Street, Suite #6 State College, PA 16801
Office Number: (814) 466-6396

Please bring this completed form to your upcoming appointment along with a photo ID and insurance information.

PATIENT INFORMATION	
Full Name: Preferred Name:	DOB (MM/DD/YYY): ___/___/_____ Sex: Male ___ Female: ___ Identifying gender: _____
Name of Primary Care Physician	Name of Referring Physician:
Telephone Number: Cell #: Home#:	Address:
Marital Status:	Occupation:
Preferred Language:	Preferred Pharmacy:

What is the **MAIN** reason for your Ear, Nose, & Throat Appointment? _____

Have you ever had any of following conditions?

	Yes	No	Describe			Yes	No	Describe
Heart Disease					Diabetes			
Heart Attack					Asthma			
Pacemaker					COPD/Emphysema			
Irregular heartbeat					Seasonal Allergies			
High Blood Pressure					Kidney Disease			
Stroke					Autoimmune disorder			
Cancer					Glaucoma			
Chemotherapy					Acid Reflux /Heartburn			
Seizures					Stomach Ulcers			
Bleeding disorders					Psychological Problems			

Do you have any medical problems for which you see a physician regularly that [is/are] NOT listed above? **Yes / No**

Please Describe: _____

Surgical History: Please list prior surgeries

Have you ever had an adverse reaction to anesthesia? **Yes / No** If yes, please describe: _____

Do you have a family history of life threatening reaction to anesthesia or malignant hypothermia: **Yes / No**

Allergies (please list):

Allergen	Reaction		Allergen	Reaction

Additional Allergies: _____

Do you have an allergy to contrast dye or iodine? **Yes / No** Do you have an allergy to latex? **Yes / No**

Do you have environmental allergies? **Yes / No.** If Yes, please list: _____

Medications (please list):

Name	Dose		Name	Dose

Additional Medications: _____

Females ONLY: ___# of pregnancies ___# of children

Pediatrics ONLY:

Is your child enrolled in daycare? **Yes / No**

Has the your child been exposed to second hand smoke? **Yes / No**

Social history:

Have you ever smoked? **Yes / No**

If **yes**: What product did you smoke? _____ How much did you smoke? _____. Quit date: _____

Do you currently smoke? **YES/NO**

If **yes**, what do you smoke? _____. How much do you smoke? When did you start smoking? _____

Do you use smokeless tobacco products**? Yes / No** If **yes**, what do you use? _____

Do you drink alcohol? **Yes / No** If **yes**, how much do you drink? _____

Do have a history of drug abuse? **Yes / No** If **yes**, please describe: _____

Family History: Has anyone who you are related to by blood had the following conditions:

	YES	NO	FAMILY MEMBER			YES	NO	FAMILY MEMBER
Hearing Loss					Allergies			
High Blood Pressure					Heart Disease			
Stroke					Asthma			
Cancer					Bleeding Disorders			

Patient Signature: _____ Date: __/__/____

*Please note that if you are late to your appointment, there is a chance you may have a longer wait time be asked to reschedule the appointment. If you miss three appointments in a row, you could be dismissed from the practice. *