Pinnacle ENT
ASSOCIATES LLC
VALLEY FORGE EAR, NOSE & THROAT
ASSOCIATES DIVISION

Patient Intake

Patient Name: ______________________________ Date: ____________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Family Doctor: ____________________ Referring Doctor: ____________________

Why are you here today? ______________________________

Have you had any medicine or treatment for it? ☐ Yes ☐ No

Please List: ______________________________

____

ENT REVIEW OF SYMPTOMS

Check any of the following symptoms that pertain to you:

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

☐ Dizziness (Spinning Sensation)
☐ 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

HEADACHE

☐ Where is it located? ____________________
☐ Constant
☐ Periodic
☐ Throbbing
☐ Pressure
☐ Nausea
☐ Sensitive to Light
☐ Eye Symptoms

THROAT

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

FACE AND NECK

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

Continued on the next page.

REVIEW OF SYMPTOMS

Are you currently having any problems with your:

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, etc.	☐ Yes	☐ No
Bladder Problems	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Appetite or Weight Change	☐ Yes	☐ No			

ALLERGIES (Include medication allergies):

____
____
____

CURRENT MEDICATIONS YOU ARE TAKING:

____
____
____

SURGICAL HISTORY (Please list):

____
____
____

ARE YOU PREGNANT? ☐ Yes ☐ No

LATEX ALLERGY? ☐ Yes ☐ No

Past Medical History

Height: ______________ Weight: ______________ Age: ______________

Check if you have or have had any of the following conditions:

☐ Acid Reflux
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bleeding Disorder
☐ Bronchitis
☐ Cancer
☐ Cataracts
☐ COVID
☐ 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
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Thyroid Disorder
☐ Tuberculosis

Other Illnesses: ______________________________________

____

Any problems with blood clotting? ☐ Yes ☐ No
Family history of blood clotting problems? ☐ Yes ☐ No

Family History — Please Check All That Apply

☐ Stroke
☐ Hearing Loss
☐ TB
☐ Kidney Disease
☐ Heart Disease
☐ High Blood Pressure
☐ Arthritis
☐ Diabetes
☐ Cancer
☐ Respiratory Disease

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: ______________________

I certify that the above information is true and correct.

Patient/Guardian Signature: ______________________________________

Reviewed by: ______________________ M.D./PA-C Date: ______________