Pinnacle ENT ASSOCIATES LLC

CHESTER COUNTY OTOLARYNGOLOGY & ALLERGY ASSOCIATES DIVISION

Patient Intake

Name: _____ DOB: _____ Appointment Date: _____

What is the purpose of today's visit? _____

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

Did they refer you to us? ☐ Yes ☐ No If no, who did? _____

Who are your other physicians? _____

GENERAL MEDICAL INFORMATION

Patient's Weight (lbs): _____ Height: _____

List ALL Current Medical Conditions (treated and untreated): _____

_____

List ALL 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 ✓ if there is a history of the following:

Mother	☐ Heart Disease	☐ Lung Disease	☐ Cancer	☐ Bleeding Disorder	☐ Anesthesia Complications
Father	☐ Heart Disease	☐ Lung Disease	☐ Cancer	☐ Bleeding Disorder	☐ Anesthesia Complications
Siblings	☐ Heart Disease	☐ Lung Disease	☐ Cancer	☐ Bleeding Disorder	☐ Anesthesia Complications

Name: _____ DOB: _____ Appointment Date: _____

SOCIAL HISTORY

Do or did you ever smoke/chew/cigars/pipe? ☐ Yes ☐ No When did you quit? _____

Did you ever take recreational/street drugs? ☐ Yes ☐ No What, how much & when? _____

Do you drink alcohol? ☐ Yes ☐ No Ounces per day: _____

Caffeine intake (coffee, tea, iced tea, chocolate) per day: _____

What kind of work do you do? _____

FOR CHILDREN: Is your child up to date with immunizations? ☐ Yes ☐ No

REVIEW OF SYMPTOMS

Please ✓ 'YES' for any of the following diseases or symptoms you have experienced RECENTLY:

CONSTITUTIONAL:	Fevers	☐ Yes ☐ No
CVS:	Chest Pain	☐ Yes ☐ No
PULM:	Cough	☐ Yes ☐ No
GI:	Heartburn	☐ Yes ☐ No
MSK:	Neck Pain	☐ Yes ☐ No
PSY:	Anxiety	☐ Yes ☐ No
DERM:	Hives	☐ Yes ☐ No
ENDO:	Thyroid Problems	☐ Yes ☐ No
NEUR:	Neurologic Disorder	☐ Yes ☐ No
ID:	Immune Disorder	☐ Yes ☐ No
HEME:	Bleeding/Bruising	☐ Yes ☐ No

Weight Loss	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Skin Cancer	☐ Yes ☐ No
Thyroid Cancer	☐ Yes ☐ No

FOR FEMALES: Are you currently pregnant? ☐ Yes ☐ No

Other: _____

_____

_____