Pinnacle ENT
ASSOCIATES, LLC
EAR • NOSE • THROAT • ALLERGY • AUDIOLOGY

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? ☐ Yes ☐ 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

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: _____

_____

_____

For 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