Pinnacle ENT | ALIGN ENT+ Allergy Partner

Patient Intake

Name _____ **DOB** _____ **Appointment Date** _____

What is the purpose of today's visit? _____

Have you had any previous tests related to this issue? ☐ Yes ☐ No

Have you seen any other medical providers related to this issue? ☐ Yes ☐ No

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 Prolapse
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Pacemaker/Defibrillator
☐ Pneumonia
☐ Prostate Disorder
☐ Psychiatric Disorder
☐ Seizures
☐ Stomach Ulcers
☐ Thyroid Disorder
☐ Tuberculosis

Other Illnesses _____

_____

Family Medical History—Please check all that apply

	Mother	Father	Sibling		Mother	Father	Sibling
Stroke	☐	☐	☐	Arthritis	☐	☐	☐
Hearing Loss	☐	☐	☐	Blood Clotting Issues	☐	☐	☐
Kidney Disease	☐	☐	☐	Cancer	☐	☐	☐
Heart Disease	☐	☐	☐	Respiratory Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐	Other _____	☐	☐	☐

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

Name _____ **DOB** _____ **Appointment Date** _____

List ALL ENT-Related Surgeries (include year) _____

_____

List ALL Other Surgeries (include year) _____

_____

List ALL Hospitalizations (include year) _____

_____

List ALL DRUG allergies _____

_____

List ALL other allergies _____

_____

List ALL Medications & Doses (include over-the-counter)

_____

_____

_____

_____

_____

_____

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 _____			
Caffeine	☐ Yes ☐ No	If yes, how many cups per day _____			

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