ENTICARE
Ear • Nose • Throat

REASON FOR TODAY'S VISIT: _____ DATE: _____

PATIENT INFORMATION:

Patient Name: _____ DOB: _____/_____/_____ Age: _____

Responsible Party/Guardian (if patient is a minor): _____ Phone: _____

SSN #: _____ Driver License #: _____ State: _____

Preferred method for appointment reminders (check all that apply): ❑ Home Phone ❑ Cell Phone ❑ Text ❑ Email

Pharmacy Name & City: _____ Cross Street: _____ Phone: _____

REFERRAL INFORMATION:

Referring Facility: _____ Address / Location: _____

Referring Provider Full Name: _____ Phone: _____

Primary Care Physician Full Name: _____ Phone: _____

Federal Privacy Standards require the following information:

Race: ❑ White ❑ Hispanic ❑ Asian ❑ African American ❑ American Indian / Alaskan Native
❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Unreported / Refused to Report

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Refused to Report

Preferred Language: ❑ English ❑ Spanish ❑ Other

HIPAA APPROVED CONTACTS:

- *Please list the individuals you give permission to have access to and discuss your protected health information.*
- *Write **'NONE'** if there are no authorized individuals.*

Name	Date of Birth	Phone Number	Relationship	Emergency Contact
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

What is your Height? _____ Weight? _____

Female Patients Only: Are you now or is there a chance that you are pregnant? ❑ Yes ❑ No

MEDICATIONS: ❑ None

- *Please list all the medications you are taking, including supplements (attach list as needed).*

THE EPWORTH SLEEPINESS SCALE

- How likely are you to doze off or fall asleep in the following scenarios in contrast to just feeling tired?
- Even if have not done some of these thing recently, try to work out how they would have affected you.
- Use the scale to choose the most appropriate number for each situation and circle the correct one.

0 = Would Never Doze
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

SCENARIO	CHANCE OF DOZING
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in public place, e.g., theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
In a car, while stopped in a few minutes of traffic	0 1 2 3

HEARING HISTORY QUESTIONNAIRE

Please circle the appropriate response for each symptom.

Ringing or other sounds in ears	Yes	No
Chronic ear infections	Yes	No
Earwax build up	Yes	No
Fullness in ears	Yes	No
Pressure in ears	Yes	No
Perforated eardrum	Yes	No
Family history of hearing loss	Yes	No
Exposed to loud noises	Yes	No
Trauma to head	Yes	No
Dizziness or vertigo	Yes	No
Sinus or allergy problems	Yes	No
Have you had a hearing test?	Yes	No
Have you had ear surgery?	Yes	No

ALLERGY HISTORY QUESTIONNAIRE

How long have you had allergy symptoms? _____

Year-round or seasonal?_____

Have you been allergy tested before? _____

If yes, did you receive immunotherapy? _____

Are you exposed to fumes, chemicals or dust at work?_____

What prescription medication have you tried for allergies? For how long?

PRESCRIPTION	FOR HOW LONG

Please circle the appropriate number 1-5 according to severity:

0 = no problem | 1 = mild | 5 = very severe

Nasal discharge	0 1 2 3 4 5
Nasal obstruction	0 1 2 3 4 5
Watery or itchy eyes	0 1 2 3 4 5
Sneezing	0 1 2 3 4 5
Wheezing	0 1 2 3 4 5
Cough	0 1 2 3 4 5
Itching	0 1 2 3 4 5
Eczema	0 1 2 3 4 5
Hives	0 1 2 3 4 5
Headache	0 1 2 3 4 5
Chronic fatigue	0 1 2 3 4 5
Food intolerance	0 1 2 3 4 5
Frequent sinus or ear infections	0 1 2 3 4 5
Frequent colds or sore throats	0 1 2 3 4 5
Learning disability	0 1 2 3 4 5
Poor memory or concentration	0 1 2 3 4 5
Hyperactivity	0 1 2 3 4 5
Abdominal gas or cramping	0 1 2 3 4 5
Arthritis or muscle aching	0 1 2 3 4 5
Asthma	0 1 2 3 4 5