



E A R , N O S E & T H R O A T C E N T E R O F T H E O Z A R K S

Thank you for choosing the Ear, Nose, and Throat Center of the Ozarks to provide your health care. Enclosed are the forms for you to review or complete prior to your appointment.

The staff at the Ear, Nose, and Throat Center of the Ozarks is committed to providing thorough examinations, comprehensive diagnoses and treatments, and detailed answers to your questions. Please assist your doctor by completing the questionnaire(s) enclosed in this packet. **Please fill out every item.** It is important for your doctor to know that you have reviewed every area of this form.

Thank you for your time and assistance. If you have any questions when completing the accompanying forms, please do not hesitate to ask for our assistance.

Patient Information

Acct # _____

Last Name _____ First _____ Middle Initial _____ Sex M F (circle) Marital Status S M W D

Address _____ City _____ State _____ Zip _____

S.S. # _____ Date of Birth _____ (mm/dd/yyyy) Age _____ Weight _____ Height _____

Home Phone Number () _____ - _____ Work Phone () _____ - _____

Cell Phone Number () _____ - _____ Alternate Phone Number () _____ - _____

Email _____ Race _____ Ethnicity _____

Pharmacy Preference, if any (please include location) _____

Employer _____ Language Preference _____

Spouse's Name _____ S.S.# _____ Date of Birth _____

Spouse's Employer _____ Work Phone Number () _____ - _____

Name of Insurance Company _____ Group Number _____

Name of Primary Insured _____ I.D. Number _____

If the patient is a minor, please fill in the following information:

Mother's/Guardian's Name _____ S.S.# _____ Date of Birth _____

Employer _____ Work Phone Number () _____ - _____

Father's Name _____ S.S.# _____ Date of Birth _____

Employer _____ Work Phone Number () _____ - _____

Name of Primary Care Physician _____ Name of Referring Physician _____

Reason for Today's Visit _____ What is the main symptom that bothers you? _____

How long have you had this? _____ Have you been treated for this before? _____

I understand that the payment is expected when services are provided. Payment in full will be required if insurance cannot be verified.

Method of payment for today's visit: CASH CHECK CREDIT CARD

I authorize Ear, Nose and Throat Center of the Ozarks to provide medical care. I authorize the release of any medical information necessary to provide medical care process insurance claims and payments of medical benefits to physician and supplier.

I hereby acknowledge that this facility employs video surveillance equipment for security purposes only.

I hereby acknowledge that I have had an opportunity to read the privacy practices of the Ear, Nose and Throat Center for the Ozarks. (Notice of privacy practices is posted in the waiting area. A copy of this can be obtained from our receptionist.)

Signature _____ Date _____

Name _____

Please list any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal therapy, and cold medications that you are currently taking.

Medication	Dose (Strength)	How Often Taken	Medication	Dose (Strength)	How Often Taken

Are there more medications than the space provided? YES NO If yes, please present a list.

Are there any medications that you have taken in the last month and are no longer using? YES NO
If yes, then what medication(s)? _____

Have you taken any ibuprofen or aspirin containing products in the last two weeks? YES NO

Have you taken any steroid or cortisone drugs within the last year? YES NO

Do you take antibiotics prior to dental work or any other procedure? YES NO

Are there medications which you have had an allergic reaction or unpleasant side-effect? YES NO
If yes, please describe the medication and reaction in the space below. If more than space allows, please present a list.

Medication	Reaction	When this occurred

Are you allergic to any of the following? If yes, please circle. LATEX TAPE IODINE or CONTRAST DYE

Do you have any other allergies? If so, please list them and discuss with your physician _____

What is your occupation? _____ Have you been exposed to loud noise? YES NO

Do you have regular hearing screening at your job? YES NO When was your last hearing screening? _____

Do you have hobbies or other activities that have exposed you to loud noise? YES NO

Have you ever used tobacco(circle one)? NEVER YES, IN THE PAST YES, CURRENTLY USE

If yes, how much? _____ If yes, how long? _____

Have you ever used alcohol(circle one)? NEVER YES, IN THE PAST YES, CURRENTLY USE

If yes, how much? _____ If yes, how long? _____

Have you ever been treated with radiation(circle one)? NEVER YES, IN THE PAST YES, CURRENTLY

If yes, when? _____ If yes, how long? _____

If the patient is a child, what daycare/school do they attend? _____

Do you have any pets? YES NO List _____

Name _____

Have you ever had problems with (please circle):

List:

Eyes	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Ears	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Nose or sinuses	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Tonsils	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Throat or Voice	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Thyroid, parathyroid, or endocrine system	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Immune system or HIV	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Hypertension/High Blood Pressure	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Heart	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Lungs	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Esophagus (food or swallowing pipe)	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Stomach or stomach ulcers	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Bowel (small or large intestine, rectum)	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Lymph nodes or spleen	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Liver disease, hepatitis, or jaundice	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Gall Bladder or pancreas	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Kidneys or Bladder	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Neurologic disease, epilepsy, or seizures	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Bones, muscles, or joints (including TMJ)	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Back, neck, or spine	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Excessive bleeding or bleeding tendency	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
Any eye problem not corrected by glasses	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
FEMALES: Uterus, ovaries, breasts	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____
MALES: Prostate, penis, testicles	NO PROBLEM	MEDICAL PROBLEM	SURGERY	_____

Have you ever had any surgery? YES NO
If yes, please list surgeries and dates _____

Have you ever been hospitalized? YES NO

If yes, please list reasons and dates _____

Have you or do you have any medical conditions that you have not listed? YES NO

If yes, please list them _____

Name _____

Have you ever had any of the following treatments for problems in the ear, nose, throat, head or neck regions (please circle):

Hearing Aids	Yes	No	When _____	Ear Drops	Yes	No	What/When _____	Ear Trauma	Yes
Treatment for Vertigo				Yes	No	What/When _____			
	No		What/When _____						
Ear Surgery	Yes	No	What/When _____	Ear Cleaning	Yes	No	What/When _____		
Sinus/Allergy Medication	Yes	No	What/When _____	Sinus/Nose Surgery	Yes	No	What/When _____		
Allergy Shots	Yes	No	What/When _____	Nasal Sprays	Yes	No	What/When _____		
Nasal Irrigations/Washes	Yes	No	What/When _____	Nasal Trauma	Yes	No	What/When _____		

Systems Review:

In the past few months, have you had:

<input type="checkbox"/> fever within the last month	<input type="checkbox"/> night sweats	<input type="checkbox"/> excessive bruising
<input type="checkbox"/> enlarged lymph nodes or glands		<input type="checkbox"/> change in a mole
<input type="checkbox"/> double or blurred vision	<input type="checkbox"/> seizures	<input type="checkbox"/> recurrent infections
<input type="checkbox"/> tick or insect bite(s)	<input type="checkbox"/> animal bite or scratch	
<input type="checkbox"/> diminished hearing	<input type="checkbox"/> dizziness or vertigo	<input type="checkbox"/> ringing in the ears
<input type="checkbox"/> ear fullness	<input type="checkbox"/> drainage from the ears	<input type="checkbox"/> ear injury
<input type="checkbox"/> sinus problems	<input type="checkbox"/> significant headaches	<input type="checkbox"/> seasonal allergies
<input type="checkbox"/> post nasal drainage	<input type="checkbox"/> sneezing/itchy nose	<input type="checkbox"/> loss of sense of smell
<input type="checkbox"/> runny nose	<input type="checkbox"/> nose bleeds	<input type="checkbox"/> face pain or pressure
<input type="checkbox"/> sinus infection requiring antibiotics	<input type="checkbox"/> difficulty breathing through your nose	
<input type="checkbox"/> NONE		

Are you bothered by difficulty:

<input type="checkbox"/> wheezing	<input type="checkbox"/> coughing	<input type="checkbox"/> swallowing
<input type="checkbox"/> hoarseness	<input type="checkbox"/> speech difficulty or changes	<input type="checkbox"/> chronic halitosis/"bad breath"
<input type="checkbox"/> snoring	<input type="checkbox"/> throat pain	<input type="checkbox"/> pain when you drink citrus
<input type="checkbox"/> NONE		

Have you:

<input type="checkbox"/> had "heartburn" or reflux	<input type="checkbox"/> coughed up sputum	<input type="checkbox"/> been exposed to TB
<input type="checkbox"/> been diagnosed with asthma	<input type="checkbox"/> coughed up blood	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> "blacked out" (lost consciousness)		<input type="checkbox"/> had weakness or tingling

had neurological changes

<input type="checkbox"/> had abnormal pain or swelling of the legs or feet	<input type="checkbox"/> had irregular heart beats
<input type="checkbox"/> had heart valve problems	<input type="checkbox"/> had chest pain or pressure
<input type="checkbox"/> NONE	<input type="checkbox"/> had rapid heart beats

Do you have:

<input type="checkbox"/> stomach trouble	<input type="checkbox"/> significant constipation	<input type="checkbox"/> significant diarrhea
<input type="checkbox"/> blood in your bowel movements	<input type="checkbox"/> nausea or vomiting	<input type="checkbox"/> pain in your abdomen
<input type="checkbox"/> excessive urination	<input type="checkbox"/> burning with urination	<input type="checkbox"/> pain with urination
<input type="checkbox"/> difficulty completely emptying your bladder	<input type="checkbox"/> difficulty with leaking urine from your bladder	
<input type="checkbox"/> joint pain, stiffness, or swelling	<input type="checkbox"/> muscle pain or stiffness	<input type="checkbox"/> back pain or stiffness
<input type="checkbox"/> NONE		

Signature _____ Date _____

Thank you very much for your time. These forms will help us serve you better.