

NORTHERN JERSEY EAR, NOSE AND THROAT ASSOCIATES

44 GODWIN AVENUE • SUITE 300 • MIDLAND PARK, NJ 07432

1 DEGRAW AVENUE • TEANECK, NJ 07666

PLEASE ANSWER ALL QUESTIONS - PLEASE PRINT

DR REFERRED BY _____

E-MAIL ADDRESS: _____

ADDRESS _____

DATE: _____ DOCTOR YOU ARE SEEING _____ REASON FOR TODAY'S VISIT _____

PATIENT'S NAME - FIRST _____ LAST _____ AGE _____ SEX _____

ADDRESS _____ TOWN _____ STATE _____ ZIP _____

HOME PHONE _____ SOCIAL SECURITY # _____ BIRTH DATE _____

PLACE OF BUSINESS _____ BUSINESS PHONE _____ CELL PHONE _____

PARENT'S NAME (IF PATIENT IS A MINOR) _____

INSURANCE PARTICIPATING LABORATORY _____

PHARMACY OF CHOICE: _____ TOWN _____ PHONE _____

MEDICAL INSURANCE - PRIMARY _____ ID# _____ GROUP # _____

ADDRESS _____ TOWN _____ STATE _____ ZIP _____

POLICY HOLDER'S NAME _____ SOCIAL SECURITY # _____ BIRTH DATE _____

ADDRESS _____ TOWN _____ STATE _____ ZIP _____

SECONDARY _____ ID# _____ GROUP # _____

ADDRESS _____ TOWN _____ STATE _____ ZIP _____

POLICY HOLDER'S NAME _____ SOCIAL SECURITY # _____ BIRTH DATE _____

ADDRESS _____ TOWN _____ STATE _____ ZIP _____

EMERGENCY CONTACT PERSON _____ PHONE _____

IS VISIT RELATED TO AN AUTO ACCIDENT OR IS IT A WORKMAN'S COMP CASE? () NO () YES

IF YOU HAVE ANY OF THESE PROBLEMS, PLEASE CIRCLE

Eyes

- Infections/Injuries
- Glaucoma
- Cataracts

Respiratory

- Asthma
- Chronic Cough
- Emphysema
- Shortness of Breath
- Bronchitis
- Pneumonia
- Lung Cancer
- Bloody Sputum

Neurological

- Seizures
- Problems with Your Memory
- Disorientation
- Difficulty with Your Speech
- Inability to Concentrate
- Double or Blurred Vision
- Face Weakness
- Coordination in Arms &/or Legs

Allergic Immunologic

- Food Allergies
- Inhalant (nasal) Allergies
- Immunologic Disorders

Ear, Nose, Throat & Mouth

- Hearing Loss
- Ear Pain/Infections
- Ringing in Ears
- Balance Disturbance (e.g. Vertigo, Spinning)
- Nosebleeds
- Nasal Congestion
- Frequent Nasal Drainage Color _____
- Inability to Smell
- Sinus Problems
- Frequent Sore Throats
- Mouth Sores

Genitourinary

- Urinary Tract Infections
- Painful Urinations
- Blood in Your Urine
- Difficulty Starting or Stopping Stream
- Incontinence
- Kidney Stones
- Prostate Cancer (males)
- Endometriosis (females)
- Uterine/Cervical Cancer (females)

Gastrointestinal

- Indigestion or Pain With Eating
- Nausea
- Vomiting
- Liver Disease
- Jaundice
- Abdominal Pain
- Change in Your Bowel Habits
- Ulcers or Gastritis
- Colon Cancer

Hematologic/Lymphatic

- Anemia
- Hemophilia
- Bleeding Tendencies
- Persistent Swollen Glands or Lymph Nodes
- Blood Transfusion
- If yes, when? _____

Constitutional

- Fever
- Weight Loss
- Excessive Fatigue
- Night Sweats
- Headache

Cardiovascular

- Chest Pain or Angina
- High Blood Pressure
- Irregular Pulse
- Heart Murmur
- Swelling in Feet or Hands

Musculoskeletal

- Arm or Leg Pain/Weakness
- Back Pain
- Joint Pain or Swelling
- Arthritis

Endocrine

- Diabetes
- Thyroid Disease
- Increased Appetite
- Excessive Thirst or Urination
- Hormone Problems

Psychiatric

- Anxiety
- Depression
- Other Psychiatric Disorder/Treatment

Integumentary

- Skin Disease
- Skin Cancer

PAST MEDICAL HISTORY

Please list any prior major illnesses or injuries:

Please list any Surgeries or Hospitalizations (and the year):

Have you had problems with anesthesia? () No () Yes Describe _____
Have any family members had high fever from anesthesia? () No () Yes
Have you had any reaction from contact to latex ? () No () Yes

Please list current medications (Please include vitamins, nutrients, herbs, "natural medicines", etc.)

Medication	Dose	Frequency

Do you take aspirin containing products, Advil or Motrin, or blood thinners? () No () Yes

Do you take Birth Control pills? () No () Yes
Is there any chance that you are currently pregnant? () No () Yes

Do you have any medication allergy? () No () Yes (Please list below)

Medication	Type of Reaction

Marital Status: () S () M () D () W
Do you have children? () No () Yes Ages: _____
Do You live alone? () No () Yes

Do you smoke cigarettes, cigars, and/or chew tobacco? () No () Yes (_____ quantity/day for _____ years)
() I quit _____ yrs. ago but before that smoked _____ quantity/day for _____ yrs)

Do you drink Alcohol? () No, never (or rarely) () No, but I used to drink heavily
() Yes () Daily () 1 or more times weekly () 1 or more times monthly

Are you at risk for blood borne diseases (i.e. by blood transfusion, by I.V. drug use or by sexually transmitted disease)?
() No () Yes _____

Please list any serious illnesses in close family members, or any "hereditary diseases" that run in your family:

SIGNATURE ON FILE
