

**University Ear, Nose and Throat Specialists, Inc.**  
**Patient Medical History**

**PLEASE FILL OUT COMPLETELY**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

MRN#: \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Height \_\_\_\_\_ ft. \_\_\_\_\_ in.

Primary Complaint/Why are you here? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

Do you have **any allergies** to drugs or medications?  Yes  No **Are you allergic to Latex?**  Yes  No

If yes, please explain: \_\_\_\_\_

List any **medications and dosage (prescription and/or herbal)** you are on presently:

- |                     |                     |
|---------------------|---------------------|
| 1) _____ dose _____ | 2) _____ dose _____ |
| 3) _____ dose _____ | 4) _____ dose _____ |
| 5) _____ dose _____ | 6) _____ dose _____ |
| 7) _____ dose _____ | 8) _____ dose _____ |

**Personal History:** Please check any of the following medical conditions, which you **have now or have had in the past:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> diabetes       | <input type="checkbox"/> high blood pressure  | <input type="checkbox"/> heart problems         | <input type="checkbox"/> scarring/keloids               |
| <input type="checkbox"/> asthma         | <input type="checkbox"/> chronic bronchitis   | <input type="checkbox"/> bleeding problems      | <input type="checkbox"/> infection/boils                |
| <input type="checkbox"/> seizures       | <input type="checkbox"/> psychiatric problems | <input type="checkbox"/> allergies or hay fever | <input type="checkbox"/> reaction to local anesthetic   |
| <input type="checkbox"/> liver disease  | <input type="checkbox"/> kidney disease       | <input type="checkbox"/> frequent heartburn     | <input type="checkbox"/> reaction to general anesthetic |
| <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> visual problems      | <input type="checkbox"/> bone or joint problems | <input type="checkbox"/> thyroid problems               |
| <input type="checkbox"/> HIV/AIDS       | <input type="checkbox"/> cancer Type _____    | <input type="checkbox"/> immunologic problems   | <input type="checkbox"/> Other _____                    |

Briefly comment on any of the above conditions which have been checked: \_\_\_\_\_

Have you ever had allergy testing?  YES  NO If YES, when and by whom? \_\_\_\_\_

Are you currently or have you ever had allergy shots?  YES  NO

How many times per year do you get sinusitis? \_\_\_\_\_

Is your sense of taste normal?  YES  NO Is your sense of smell normal?  YES  NO

Have you ever had CAT Scans, X-rays or MRI?  YES  NO  
If YES, When? \_\_\_\_\_ Where? \_\_\_\_\_ Of what? \_\_\_\_\_

If injury, date of injury: \_\_\_\_\_

Type of injury:  Motor Vehicle  Pedestrian  Animal Bite  At Work  Other \_\_\_\_\_

**Family History:** Please check any of the following medical conditions in your immediate family:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> diabetes             | <input type="checkbox"/> high blood pressure  | <input type="checkbox"/> heart problems         | <input type="checkbox"/> thyroid problems       |
| <input type="checkbox"/> asthma               | <input type="checkbox"/> chronic bronchitis   | <input type="checkbox"/> bleeding problems      | <input type="checkbox"/> bone or joint problems |
| <input type="checkbox"/> seizures             | <input type="checkbox"/> psychiatric problems | <input type="checkbox"/> allergies or hay fever | <input type="checkbox"/> visual problems        |
| <input type="checkbox"/> liver disease        | <input type="checkbox"/> kidney disease       | <input type="checkbox"/> frequent heartburn     | <input type="checkbox"/> stomach ulcers         |
| <input type="checkbox"/> immunologic problems | <input type="checkbox"/> cancer Type _____    | <input type="checkbox"/> Other _____            |   |

Briefly comment on any of the above conditions which have been checked: \_\_\_\_\_

**Social History:**

Have you ever used tobacco of any kind?  YES  NO

How long ago did you start using tobacco? \_\_\_\_\_

How many packs per day? \_\_\_\_\_

Do you drink Alcohol?  YES  NO

Have you or do you use illicit drugs:  YES  NO

If YES, type of tobacco: \_\_\_\_\_

Do you smoke now?  YES  NO

If NO, how long ago did you quit \_\_\_\_\_

Approximately how much per week? \_\_\_\_\_

If YES, type \_\_\_\_\_

May we leave tests results, etc. on your answering machine if you are not available?  YES  NO

Physician signature \_\_\_\_\_ Date \_\_\_\_\_

**UNIVERSITY EAR, NOSE, AND THROAT SPECIALISTS, INC.**

222 Piedmont Avenue, Suite 5200

7700 University Court, Suite 3900

Cincinnati, OH 45219

West Chester, OH 45069

(513) 475-8400 or (800) 272-4645

Date: \_\_\_\_\_ Physician being seen: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_

Name you would like to be called: (Nickname) \_\_\_\_\_ Social Security#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M or F (Circle One) Race: \_\_\_\_\_

Marital Status: (Circle One) Married Single Divorced Separated Widow/er

Address: \_\_\_\_\_ Apt./Unit# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ Cellular / Pager #: (\_\_\_\_\_) \_\_\_\_\_  
(circle one)

Email Address (if available): \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_\_) \_\_\_\_\_

Guarantor Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_  
First Name Last Name

Address: \_\_\_\_\_

Nearest friend/relative(not living with you): \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Relationship to Patient: (Circle one) Spouse Parent Grandparent Daughter Son Friend Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is this injury related?  Yes  No Date of injury: \_\_\_\_\_

Type of injury:  Motor Vehicle  At Work  Pedestrian  Animal Bite  Other \_\_\_\_\_

Do you have the injury related coverage information other than health insurance?  Yes  No

**If motor vehicle accident related, please provide auto insurance information.**

**Primary Insurance:** Name of Insurance Company: \_\_\_\_\_

Insurance Effective Date: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Name of Primary Person Insured: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address of Insured (if different than patient address) \_\_\_\_\_

Relationship to Cardholder: (Circle One) Self Spouse Parent Grandparent Other: \_\_\_\_\_

**Secondary Insurance:** Name of Insurance Company: \_\_\_\_\_

Insurance Effective Date: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Name of Primary Person Insured: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address of Insured (if different than patient address) \_\_\_\_\_

Relationship to Cardholder: (Circle One) Self Spouse Parent Grandparent Other: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Surgical History:**

Have you ever had nasal trauma or a broken nose?      N    Y    Head trauma?      N    Y  
Have you ever had nasal or sinus surgery?              N    Y    If YES, describe what type of surgery and when it was performed :

Have you ever had ear, brain, neck or mouth surgery?      N    Y    If YES, describe what type of surgery and when it was performed :

Other Surgeries:

Operation / Hospitalization                                      Year:      Complications, if any

*Please circle yes or no relating to symptoms you are currently experiencing:*

<b>GENERAL</b>			<b>Endocrine</b>		
anorexia-(loss of appetite)	N	Y	cold intolerance	N	Y
chills	N	Y	heat intolerance	N	Y
fatigue	N	Y	hyperthyroidism	N	Y
fevers	N	Y	hypothyroidism	N	Y
sweats	N	Y	<b>Allergic/Immunologic</b>		
weight gain	N	Y	hay fever	N	Y
weight loss	N	Y	HIV exposure	N	Y
<b>ENT</b>			asthma	N	Y
decreased hearing	N	Y	urticaria (hives)	N	Y
dysphagia-(difficulty swallowing)	N	Y	<b>EYES</b>		
ear discharge	N	Y	blurring	N	Y
earache	N	Y	diplopia-(double vision)	N	Y
facial pain	N	Y	photophobia-(light sensitivity)	N	Y
headaches	N	Y	vision loss	N	Y
hoarseness	N	Y	<b>Cardiovascular</b>		
mouth ulcers/sores	N	Y	chest pain	N	Y
nasal congestion	N	Y	palpitations	N	Y
nosebleeds	N	Y	syncope-(fainting)	N	Y
post nasal drip	N	Y	dyspnea on exertion-(short of breath with activity)	N	Y
rhinorrhea – (runny nose)	N	Y	<b>Gastrointestinal</b>		
sinusitis	N	Y	acid regurgitation	N	Y
sinus pain	N	Y	heartburn	N	Y
sore throat	N	Y	<b>Musculoskeletal</b>		
sneezing	N	Y	arthritis	N	Y
tinnitus – (ringing in ears)	N	Y	joint pain	N	Y
<b>Respiratory</b>			muscle weakness	N	Y
dyspnea– (shortness of breath at rest)	N	Y	<b>Skin</b>		
wheezing-(breathe w/ difficulty/making noise)	N	Y	rash	N	Y
dry cough	N	Y	dry skin	N	Y
<b>Genitourinary</b>			itching	N	Y
dysuria-(painful urination)	N	Y	suspicious lesions	N	Y
hematuria-(blood in urine)	N	Y	<b>Psychiatric</b>		
Kidney Stones	N	Y	depression	N	Y
<b>Neurological</b>			anxiety	N	Y
headaches	N	Y	<b>Hemo/Lymphatic</b>		
weakness	N	Y	abnormal bruising	N	Y
paresthesias–(abn.sensation of burning/tingling)	N	Y	bleeding	N	Y
			enlarged lymph nodes	N	Y

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**DISCLOSURE TO FAMILY/FRIENDS**

I hereby authorize \_\_\_\_\_  
(Physician / UCP Practice) to discuss the following with the person/persons listed below.

- ( ) Condition/Treatment/Plan of Care
- ( ) Diagnostic Test Results
- ( ) Lab Results

I understand that this authorization is voluntary and that it may include information relating to AIDS, HIV, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse. I understand that if the person/entity that receives my Protected Health Information is not covered by Federal Privacy regulations, the PHI described below may be re-disclosed by such person or entity.

Allowed person/persons

<u>Name</u>	<u>Relation</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information.

Patient Name / Legal Representative \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

