Proliance South Seattle Otolaryngology

Patient Information

Patient Name _____ Date_____
Address _____
City, State, Zip _____ Sex □ Male □ Female
Home Phone _____ Work Phone _____
Mobile Phone _____ Email _____
Communication Preference □ E-Mail □ Home Phone □ Mobile Phone
Marital Status □ Single □ Married □ Divorced □ Widowed Date of Birth _____ Age _____
Social Security # _____ Occupation _____ Employer _____

Insurance Information
Primary Insurance Provider _____
Name of Subscriber _____ Subscriber DOB _____
Subscriber ID _____ Group ID _____
Subscriber Social Security # _____
Secondary Insurance Provider _____
Name of Subscriber _____ Subscriber DOB _____
Subscriber ID _____ Group ID _____
Subscriber Social Security # _____

Primary Care Physician
Primary Care Physician _____
Address _____
City, State, Zip _____ Phone _____

Referral Information
Referring Physicians _____
Address _____
City, State, Zip _____ Authorization# (if needed) _____

Emergency Contact Information
Name and Relationship of Emergency Contact _____
Address _____
City, State, Zip _____ Phone _____

Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Decline to specify

Race □ Black or African American □ Native Hawaiian or other Pacific Islander □ White □ Other race □ Declined

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Adult Patient Health History

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Date _____/_____/_____

Patient Name _____ DOB _____ Age _____
Occupation _____
Pharmacy Name and Address _____

Medical History
Do you have or have ever had any of the following conditions? Please check:

Autoimmune Disease:
- □ Diabetes
- □ Hepatitis
- □ Thyroid disease

Cardiovascular:
- □ Atrial fibrillation
- □ Heart attack
- □ Heart murmur
- □ Heart valve disease
- □ High blood pressure

Gastrointestinal:
- □ Colitis/diverticulitis
- □ Gastroesophageal reflux (GERD)
- □ Ulcers

Genito-urinary:
- □ Gender re-assignment
- □ Kidney stones
- □ Urinary tract infections (UTIs)

Hematologic/Metabolic:
- □ Anemia
- □ Bleeding disorder
- □ Bruising

Lungs:
- □ Asthma
- □ Bronchitis/pneumonia
- □ Emphysema/COPD
- □ Tuberculosis

Musculoskeletal/Neurological
- □ Arthritis
- □ Headache/migraine
- □ Seizures

Other:
- □ Dementia/alzheimer's
- □ Glaucoma
- □ High Cholesterol
- □ HIV
- □ Neuropathy
- □ On CPAP for sleep apnea
- □ Stroke

Other medical conditions you may have:

Previous Surgery
Have you had any surgeries? (Include childhood surgery such as tonsillectomy)
□ No □ Yes (please list below

Surgery	Date

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Medications

Are you taking any prescribed or over the counter medications?

□ No □ Yes (please list below)

Medication	Dosage	Reason for taking

Are you allergic to any medications?

□ No □ Yes (please list below)

Medication	Type of Reaction

Family History

Do you have a family history (immediate family only) of medical problems? □ No □ Yes

□ Alzheimer's
□ Bleeding problems
□ Cancer
□ Diabetes
□ Hearing loss
□ Heart disease
□ High blood pressure
□ Stroke
□ Other: _____

Social History

Do you drink alcohol? □ No □ Yes If Yes, _____ drinks per week

Do you smoke cigarettes? □ No □ Yes If Yes, how much _____

If you have quit smoking when did you quit and how long did you smoke _____

Do you do any illicit drugs □ No □ Yes If Yes, what drug and how often ___

Do you drink caffeine □ No □ Yes If Yes, _____ drinks per day

Have you had or been exposed to HIV (AIDS)? □ No □ Yes

Are you pregnant? □ No □ Yes

Review of Systems

Please check only those symptoms you have developed:

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Constitutional:
- □ Anxiety
- □ Chills
- □ Fatigue
- □ Fever
- □ Headache
- □ Weight gain: How much _____
- □ Weight loss: How much _____

Eye:
- □ Blurred vision
- □ Double vision
- □ Vision-flashes

Gastrointestinal:
- □ Acid reflux
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids
- □ Nausea
- □ Poor appetite
- □ Vomiting

Genito-urinary:
- □ Blood in urine
- □ Frequent urination
- □ Lack of bladder control

Men only:
- □ Breast lump
- □ Lump in testicles

Musculoskeletal:
- □ Joint pain
- □ Muscle pain
- □ Muscle weakness
- □ Neck stiffness
- □ Teeth grinding

Women only:
- □ Abnormal pap smear
- □ Breast lump
- □ Hot flashes

Ear, Nose, Throat:
- □ Ear drainage
- □ Ear pain
- □ Difficulty swallowing
- □ Hay fever
- □ Hoarseness
- □ Loss of hearing
- □ Nosebleeds
- □ Post nasal drip
- □ Ringing in ears
- □ Sinus problems
- □ Snoring
- □ TMJ

Neurological:
- □ Balance problems/dizziness
- □ Fainting
- □ Fall asleep easily during the day
- □ Headaches
- □ Memory problems
- □ Seizure
- □ Tingling
- □ Tremors

Respiratory:
- □ Oxygen dependence
- □ Persistent cough
- □ Productive cough
- □ Shortness of breath
- □ Wheeze

Skin:
- □ Bruise easily
- □ Hives
- □ Itching
- □ Rash
- □ Scars
- □ Sores that won't heal