EAST IDAHO
EAR NOSE & THROAT

**INTAKE FORM**

Patient Name: _____ Date of Birth _____

Why are we seeing you today? _____

MEDICAL HISTORY— Please circle all conditions that apply to the patient:

| | |
|---|---|
| Allergic Rhinitis (allergic reaction in nose/eyes) | Anemia |
| Anxiety | Arthritis |
| Asthma | Atrial Fibrillation |
| Chest Pain | Circulatory System Disorder |
| Congestive Heart Failure | Depression |
| Diabetes | Emphysema |
| Gout | Headache |
| Hearing Loss | Heart Attack |
| Heartburn | Herniated Disc |
| High Blood Pressure (hypertension) | High Cholesterol |
| High Lipids | Hypothyroid |
| Insomnia | Irritable Bowel Syndrome |
| Kidney Failure | Migraine |
| Mitral Valve Disorder | Osteoporosis |
| Sinusitis | Skin Disorder |
| Stroke | Visual Impairment |

Other:_____

Do you have any family history of the above medical conditions? If yes, please list relationship(s) and condition(s): _____

_____

Immunizations up to date? Yes No

Please list previous surgeries and the dates: _____

_____

| | | | |
|---|---|---|---|
| Do you use tobacco (or are exposed)? | Yes | No | If yes, how much? _____ |
| Alcohol? | Yes | No | If yes, how much? _____ |
| Illicit Drugs? | Yes | No | If yes, how much? _____ |

Drug allergies (please list reaction)?_____

Medications (list dosage & schedule):_____

_____

Have you ever tested positive for MRSA? Yes No

If you are over age 65, have you had the pneumonia vaccination? No Yes Date: _____

If you are over age 65, have you had the Influenza vaccination? No Yes Date: _____