



BUCKHEAD ENT

ADULT PATIENT INFORMATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

| | | | | | | | |
|--|----------------------------------|----------------|---------------------|---|---|---|--|
| Patient's last name: | | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | (Former name): | | Date of Birth: | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | |
| Street address: | | | *Social Security #: | | Home phone #: () | | |
| P.O. Box: | City: | | State: | | ZIP Code: | | |
| Email Address: | | | | | | | |

EMERGENCY CONTACT INFORMATION

| | | |
|-------|---------------|-----------------|
| Name: | Relationship: | Phone #: () |
|-------|---------------|-----------------|

PATIENT EMPLOYER CONTACT INFORMATION

| | | | |
|-------------|-----------|--------------------------|-----------|
| Occupation: | Employer: | Employer phone #: () | |
| Address: | City: | State: | ZIP Code: |

SPOUSE INFORMATION (Complete only if insurance coverage is provided by spouse employer)

| | | |
|------------|----------------------|-----------------------|
| Full Name: | Social Security no.: | Date of Birth: / / |
| Employer: | | |

PATIENTS PRIMARY CARE

| |
|--|
| Patients Primary Care Doctor's Name: |
| Patients PCP's Phone #: |
| Referring Doctor's Name (if different than PCP): |
| Referring Doctor's Phone #: |

*SS#'s are required for collection purposes. If you do not wish to provide your SSN, you will be considered a self-pay patient & expected to pay for visit at time of service.

Signature: _____ Name Printed: _____

Relationship: _____ (if not the patient receiving services) Date: _____



BUCKHEAD ENT

PATIENT CURRENT SYMPTOM FORM

Please Print

Dr. Keith M. Dockery, M.D.

Today's Date: _____

Patient Name:

First: _____ Middle: _____ Last: _____

Why are you here today? Please write one paragraph describing your history. Please include **current symptoms**, and **how it has been treated** (include any prescriptions and over the counter medications, which you have taken for this condition). List any X-ray or Lab studies that have been done.

• **How long have you had this problem?** _____

• **What is your occupation?** _____

• **What is your marital status?** (Check one)

Single Married Partnered Divorced Widowed

• **Are you a smoker?** (Check one) Yes No Former

If you selected "yes" or "former", how much did you smoke? _____ packs per

(Check one) Day Week Social Smoker Rarely Smoked

If you have quit smoking, what year did you quit? _____

• **Do you drink alcohol?** (Check one) Yes No Former

If you selected "yes" or "former", how often do you drink? _____ # of drinks

(Check one) Daily Weekly Monthly Rarely Drink

If you have quit consuming alcoholic beverages, what year did you quit? _____

• **Have you used any recreational drugs in the past?** (Check one) Yes No

Patient Name:

First: _____ Middle: _____ Last: _____ Today's Date: _____

Family History (Check one)

Is there a family history of allergies or asthma? ___ Yes ___ No

Is there a family history of head and neck cancer? ___ Yes ___ No

Is there a family history of hearing loss? ___ Yes ___ No

Is there a family history of thyroid cancer? ___ Yes ___ No

Surgical History (Check one)

Do you have a history of any ear, nose, or throat surgeries? ___ Yes ___ No

If yes, select the surgeries you had and write the approximate year(s) it was done.

Ears: ___ Tubes ___ Tympanoplasty ___ Mastoidectomy ___ Stapedectomy

Other: _____

Year: _____

Nose: ___ Rhinoplasty ___ Septoplasty and/or inferior turbinate reduction

___ Endoscopic Sinus Surgery ___ Nasal Fracture Repair

Other: _____

Year: _____

Mouth: ___ Adenoidectomy ___ Tonsillectomy ___ Adenoidectomy and Tonsillectomy

___ UPPP (Uvulopalatopharyngoplasty) ___ Midfacial advancement for overbite

Other: _____

Year: _____

Neck/Throat: ___ Excision of lymph node ___ Excision of salivary gland ___ Excision of neck mass

___ Thyroidectomy ___ Tracheotomy ___ Vocal Cord Surgery

Other: _____

Year: _____

List other **MAJOR** surgeries that you have had and the year it was done:

List any **DRUG ALLERGIES** and the reaction:

| Medication Name | Adverse Reaction |
|-----------------|------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Patient Name:

First: _____ Middle: _____ Last: _____ Today's Date: _____

Do you have LATEX allergies? Yes No

Environmental and Food Allergies (Check one)

Do you have any environmental allergies? Yes No

Do you have allergy symptoms all year long? Yes No

Have you ever had an allergy test before? Yes No

Have you ever been on allergy shots? Yes No

Do you have a history of hives or rash? Yes No

Do you have a history of food allergies? Yes No

Do you have a chronic postnasal drip? Yes No

Do you get recurring sinus infections? Yes No

Do you wheeze or have trouble breathing? Yes No

Ear Problems

Do you have any problems hearing? Yes No

Do you have ringing in your ears? Yes No

Do you have any dizziness or vertigo? Yes No

Do you have regular ear pain or itching? Yes No

When was your last hearing test? _____ Was it normal? Yes No

Voice Problems

Do you have any hoarseness? Yes No

Do you have any swallowing problems? Yes No

Do you have heartburn or acid reflux? Yes No

Do you cough or clear your throat frequently? Yes No

Do you have chronic sore throat? Yes No