Ear Nose and Throat Specialists of Connecticut | ALIGN ENT+ Allergy Partner

Patient Intake

Name: _____ DOB: _____ Appointment Date: _____

What is the purpose of today's visit? _____

Have you had any previous workup related to this issue? _____

Have you seen any other medical providers related to this issue? _____

Who is your primary care physician (not group/practice, please)? _____

Did they refer you to us? o Yes o No If no, who did? _____

Who are your other physicians? _____

General Medical Information
Patient's Weight (lbs): _____ Height: _____

Medical History—Please check if you have or have had any of the following conditions

☐ Anemia	☐ Hearing Problems	☐ Multiple Sclerosis
☐ Arthritis	☐ Heart Disease	☐ Pacemaker
☐ Asthma	☐ Heart Murmur	☐ Pneumonia
☐ Bleeding Disorder	☐ Hepatitis	☐ Prostate Disorder
☐ Blood Clotting	☐ High Blood Pressure	☐ Psychiatric Disorder
☐ Bronchitis	☐ High Cholesterol	☐ Seizures
☐ Cancer	☐ HIV Positive	☐ Stomach Ulcers
☐ Cataracts	☐ Kidney Disease	☐ Thyroid Disorder
☐ Diabetes	☐ Migraine Headaches	☐ Tuberculosis
☐ Emphysema	☐ Mitral Valve	
☐ Glaucoma	☐ Mononucleosis	

Other Illnesses: _____

Current Medical Issues—Please check all that apply

Eyes	☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No
Lungs/Breathing	☐ Yes	☐ No	Numbness/Tingling	☐ Yes	☐ No
Digestion/Stomach Problems	☐ Yes	☐ No	Joint Aches/Pains	☐ Yes	☐ No
Bowel Movements	☐ Yes	☐ No	Depression/Anxiety	☐ Yes	☐ No
Bladder Problems	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Appetite/Weight Change	☐ Yes	☐ No			

Other Current Issues _____

Females: Are you currently pregnant? ☐ Yes ☐ No

For Children: Is your child up to date with immunizations? ☐ Yes ☐ No

Do you have a latex allergy? ☐ Yes ☐ No

List ALL ENT-Related Surgeries (include year)

List ALL Other Surgeries (include year)

List ALL Hospitalizations (include year)

List ALL Medications & Doses (include over-the-counter)

List ALL Allergies (drugs, food, environmental):

Family History—Please check all that apply

☐ Stroke
☐ Heart Disease
☐ Diabetes
☐ Hearing Loss
☐ High Blood Pressure
☐ Cancer
☐ TB
☐ Arthritis
☐ Respiratory Disease
☐ Kidney Disease
☐ Blood Clotting Problems
☐ Other: _____

Social History—Please check all that apply

Tobacco Use: ☐ Yes ☐ No Usage ☐ < 1 pack/day ☐ 1 pack/day ☐ > 1 pack/day

Alcohol Consumption: ☐ Yes ☐ No ☐ Daily ☐ 1-2 drinks/week ☐ 1-2 drinks/month ☐ 1-2 drinks/year

History of Substance Abuse: ☐ Yes ☐ No If yes, specify: _____

Recreational Drugs: ☐ Yes ☐ No If yes, specify: _____

ENT-Related Symptoms—Please check all that apply

Ears	Right	Left
☐ Hearing Loss	☐	☐
☐ Noise in Ears	☐	☐
☐ Ear Discharge	☐	☐
☐ Earache	☐	☐
☐ Dizziness		
☐ Off-Balance		
☐ Loud Noise Exposure ☐ Guns ☐ Job		

Nose
- ☐ Congestion or Stuffiness
- ☐ Runny Nose
- ☐ Postnasal Drip
- ☐ Nosebleeds
- ☐ Broken Nose
- ☐ Sinus Infections
- ☐ Breathing Obstruction
- ☐ Abnormality of Smell

Throat
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Cough
- ☐ Mouth Ulcers
- ☐ Heartburn

Face & Neck
- ☐ Lump in Neck
- ☐ Non-Healing Sore
- ☐ Change in Mole
- ☐ Scar
- ☐ Pain