

Form Directions: Please provide the patient information requested below. Once you have completed the entire form, please return it to the OhioHealth Ear, Nose, and Throat Physician office in person, by mail at 1770 West Fourth Street, Mansfield, Ohio, 44906, or fax the form to (419) 520-2066. All forms must be submitted prior to your initial appointment.

SECTION 1: PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Maiden Name: _____ Nickname: _____

Check all that apply to the patient: homeless does not have address does not have phone lives in nursing facility

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Residential Address: _____ Same as Mailing Address

City: _____ State: _____ Zip Code: _____ County: _____

Email: _____

Primary Home Phone: (_____) _____ Cell Phone: (_____) _____

Social Security Number: _____ - _____ - _____ Date of Birth (MM/DD/YYYY): ____/____/____

Gender: Male Female Language: _____ Marital Status: _____Religious Affiliation: _____ Race: _____ Ethnicity: Hispanic Not Hispanic**EMERGENCY CONTACT INFORMATION:**

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Preferred Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

Relationship to Patient: Mother Father Step-Mother Step-Father Foster Parent Grandparent Other: _____**PATIENT EMPLOYMENT:**

Employer Name/Address: _____

Status: Full-Time Part-Time Retired _____ Work Phone Number: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Retired Date (if applicable): _____

PATIENT MEDICAL INFORMATIONPrimary Care Provider Name (Family Physician): _____ None

What are the primary reasons for the patient's visit to our office? _____

Are you being referred to this office by another physician? Name: _____

ADVANCED DIRECTIVES

Check (✓) any that apply. Please bring a copy of any advanced directive forms with you to your next appointment.

- None DNR (Do Not Resuscitate) Living Will Do Not Place on Life Support
 Healthcare Proxy Durable POA (Power of Attorney)

GUARDIAN OR RESPONSIBLE PERSON (OF A MINOR OR OTHER PERSON):

Relationship to Patient: Mother Father Step-Mother Step-Father Foster Parent Grandparent Other: _____

Last Name: _____ First Name: _____ MI: _____

Employer Name/Address: _____

Gender: Male Female Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Preferred Phone Number: (____) _____ Alternate Phone Number: (____) _____

SECTION 2: PATIENT MEDICATIONS*

Check (✓) this box if the patient takes no medications.

	Medication Name (brand or generic name)	Medication Strength/Dosage (example: 40 mg or 5 oz)	Prescribed Medication Directions (example: one pill daily by mouth at bedtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

**If additional space is needed for Medications, please attach a list to this form.*

SECTION 3: PATIENT ALLERGIES*

Check (✓) this box if there are no known allergies.

	Specific Allergy Name or Type (medications and environmental)	Bodily Reactions to the Allergy (Itching, breathing, stomach issues, etc.)	Allergy Severity (mild, moderate, severe)	Onset Date
1				
2				
3				
4				
5				
6				
7				
8				

**If additional space is needed for Allergies, please attach a list to this form.*

SECTION 4: PATIENT PAST MEDICAL AND SURGICAL HISTORY*

Have you ever had any problems or surgeries? If you answer YES, please list the specific disease or problem and other required information related to the disease.

Check (✓) this box if the patient has no relevant past medical and surgical history.

	Disease or Problem	Date Diagnosed	Procedures, Surgeries, Tests, or Management of the Disease (include outcome and dates)	Additional Comments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**If additional space is needed for Past Medical History, please attach a list to this form.*

SECTION 5: PATIENT FAMILY MEDICAL HISTORY*

Have any of your family members (father, mother, sibling, children, or grandparents) ever had any problems or surgeries? If you answer YES, please list the specific disease or problem and other required information related to the disease.

Check (✓) this box if the patient has no relevant family medical history.

	Diagnosis or Problem	Family Member - Relation	Age of Onset	Age of Death	Additional Comments
1					
2					
3					
4					
5					
6					
7					
8					

**If additional space is needed for Family History, please attach a list to this form.*

SECTION 6: PATIENT HEARING HISTORY

Check (✓) all that apply to the patient:

- Ringing/buzzing in the ears Right Left Comments: _____
 Fullness in the ear Right Left Comments: _____
 Ear pain Right Left Comments: _____
 Hearing Loss Right Left Comments: _____
 Dizziness/off balance Comments: _____
 Noise exposure Type: _____ Noise exposure in the military

SECTION 7: PATIENT SOCIAL HISTORY

General Information

Primary Language: _____ Language Spoken at Home: _____

Hand Dominance (check ✓ one): Right Left Ambidextrous (both hands)

Highest Education Level Achieved: Elementary Middle School High School Associate Degree
 Bachelor Degree Master Degree Doctorate Other: _____

Where are you employed? _____ Occupation/Job: _____

Do you have employment restrictions or hazards? _____

Do you have any military experience? Yes No Military Type: _____

Marital and Living Status

Current Marital Status: Married Single Divorced Life Partner Legally Separated Polygamous Other _____

Have you ever been widowed? Yes No Have you ever been divorced? Yes No

Who do you live with? (Check ✓ all that apply) Husband Wife Children Siblings Parents Other: _____

Tobacco, Alcohol, and Caffeine Use

Tobacco Use (check ✓ one): Current Former Never Unknown

Type of Tobacco Use: _____ Units/Packs per Day: _____ Years Used: _____

Have you ever tried to quit smoking? (Check ✓ one): Yes No

Year Quit: _____ Longest Timeframe Tobacco Free: _____ Relapse Year: _____

If you have tried to quit smoking, what did you do to help you quit? _____

Are you exposed to passive smoke exposure? (Check ✓ one): Yes No

Are you an alcohol drinker? (Check ✓ one): Yes No

Types of Alcohol: _____ Frequency/Amount: _____

Do you use caffeine? (Check ✓ one): Yes No

Caffeine Type(s): Coffee Chocolate Energy Drink Tea Other Amount of caffeine per day: _____

Activity Level and Diet

Daily Activity Level (check ✓ one): Moderate Sedentary Vigorous

What type(s) of exercise do you do? _____

Number of times exercise per week: _____ Number of hours exercise per week: _____

Type of Diet (check ✓ all apply): 1600 calorie 1800 calorie 2000 calorie Diabetic Gluten free Healthy
 High calorie High fat High roughage High salt Junk food Low fat
 Low residue Low salt No red meat Vegan Vegetarian

Do you wear your seatbelt when you or other people drive? Yes No

SECTION 8: PATIENT PREFERRED PHARMACY

(#1) Pharmacy Name: _____ Location/City: _____

(#2) Pharmacy Name: _____ Location/City: _____

FOR OFFICE USE ONLY

Chart Abstracted by: _____

Date Received: _____

Date Abstracted: _____