CAMINO
EAR, NOSE & THROAT CLINIC

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 Physician _____

Address _____

City, State, Zip _____ Authorization # (if needed) _____

Emergency Contact Information

Name and Relationship of Emergency Contact _____

Address _____

City, State, Zip _____ Telephone _____

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

CAMINO
EAR, NOSE & THROAT CLINIC

Adult Patient Health History

Date_____ /_____ /_____

Patient Name _____ DOB _____ Age _____

Occupation _____

Pharmacy Name and Address _____

Medical History

Do you have or have you 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

Medications

Are you taking any prescribed or over the counter medicines?

☐ 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:

Constitutional:

- ☐ Anxiety
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Weight gain How much _____
- ☐ Weight loss How much _____

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

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

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

Women Only:
- ☐ Abnormal pap smear
- ☐ Breast lump
- ☐ Hot flashes