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MISSOURI
EAR, NOSE, AND THROAT
CENTER

573-214-2000 ♦ 573-214-2042 (fax)

1000 W. Nifong Blvd,
Bldg. 3, suite 100
Columbia MO 65203

PATIENT REGISTRATION FORM

Patient name: _____
(Last) (First) (MI)

Address: _____

Sex: Male O Female O Birth Date: _____ Email: _____
Social security # _____ Marital status: married/single/divorced/widowed
Primary Phone: _____ Secondary Phone: _____
Employer: _____ Occupation: _____

Ethnicity (circle): Hispanic Not Hispanic Language (circle): English Spanish Other
Race (circle): Asian African American Hispanic Caucasian Other

RESPONSIBLE PARTY OR BILL TO INFORMATION: **Check if same as above**

Full Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work/Cell Phone: _____
Social security # _____ Birth Date: _____ Age: _____
Employer: _____ Occupation: _____

INSURANCE: PLEASE PROVIDE ALL INSURANCE CARDS WHEN CHECKING IN

EMERGENCY CONTACT: _____ Relationship: _____
Home Phone: _____ Work/Cell Phone: _____

PREFERRED PHARMACY: _____ City/Town: _____

Please provide the name of your Primary Care Physician:

Dr: _____ Phone: (_____) _____

Please provide the name of the referring Physician if applicable:

Dr: _____ Phone: (_____) _____

PATIENT HISTORY FORM

Last Name: _____ First Name: _____ Middle: _____
Social Security # _____ Date of Birth: ____/____/____ Age: _____

What is the reason for your visit today?

PAST MEDICAL HISTORY

List your present medications (include over the counter):

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Medication</u>	<u>Dosage/Frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you on a blood thinner? Yes No If yes please list: _____

Indicate all past/present medical illnesses: (Fill in the CIRCLE)

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Blood Clots	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	Skin Cancer	<input type="radio"/>	<input type="radio"/>
Heart Attack	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	Lymphoma	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Leukemia	<input type="radio"/>	<input type="radio"/>
COPD(emphysema)	<input type="radio"/>	<input type="radio"/>	Reflux	<input type="radio"/>	<input type="radio"/>
Kidney Failure	<input type="radio"/>	<input type="radio"/>	Cholesteatoma	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	Chronic Ear Infections	<input type="radio"/>	<input type="radio"/>

Please list any present/past medical illnesses not listed above:

For Females: Pregnant? Yes No

Breastfeeding? Yes No

List all allergies (medication, food, etc.):

Indicate reaction

List previous surgeries/hospitalizations:

Surgery (Indicated year)

Other Hospitalizations (Indicate Year)

FAMILY HISTORY

Do you have any blood relatives with:

	<u>Yes</u>	<u>No</u>	
Hearing loss before age 40	<input type="radio"/>	<input type="radio"/>	Relation to you: _____
Bleeding Disorder	<input type="radio"/>	<input type="radio"/>	Relation to you: _____
Heart attack before age 40	<input type="radio"/>	<input type="radio"/>	Relation to you: _____
Malignant Hyperthermia (life threatening reaction or anesthesia)	<input type="radio"/>	<input type="radio"/>	Relation to you: _____

Other: _____

SOCIAL HISTORY

Do you (adult):	<u>Yes</u>	<u>No</u>	
Smoke?	<input type="radio"/>	<input type="radio"/>	If yes, how many packs per day? _____
Drink?	<input type="radio"/>	<input type="radio"/>	If yes, <5, 5-10, or >10 drinks per week? (circle one)
Chew tobacco?	<input type="radio"/>	<input type="radio"/>	
Are you a previous smoker?	<input type="radio"/>	<input type="radio"/>	If yes, when did you quit? _____
Do you have a history of alcohol or substance abuse?	<input type="radio"/>	<input type="radio"/>	
Use of IV or other street drugs?	<input type="radio"/>	<input type="radio"/>	

If child:

Does parent/caregiver smoke?	<input type="radio"/>	<input type="radio"/>
Attend Day Care?	<input type="radio"/>	<input type="radio"/>

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following? **Fill in Yes or No:**

Constitutional:	Yes	No	Respiratory:	Yes	No	Neurological:	Yes	No
Weight Loss	<input type="radio"/>	<input type="radio"/>	Wheezing	<input type="radio"/>	<input type="radio"/>	Numbness or weakness of face/extremity	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	Shortness of Breath	<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>
Reduced Appetite	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Other: _____		
Eyes:	Yes	No	COPD (emphysema)	<input type="radio"/>	<input type="radio"/>	_____		
Blurred Vision	<input type="radio"/>	<input type="radio"/>	Other: _____			Psychological/Emotional:	Yes	No
Double Vision	<input type="radio"/>	<input type="radio"/>	_____			Depression	<input type="radio"/>	<input type="radio"/>
Other: _____			Gastrointestinal:	Yes	No	Anxiety	<input type="radio"/>	<input type="radio"/>
_____			Indigestion/Heart burn	<input type="radio"/>	<input type="radio"/>	Other: _____		
Ears/Nose/Throat:	Yes	No	Stomach ulcers	<input type="radio"/>	<input type="radio"/>	_____		
Hearing loss	<input type="radio"/>	<input type="radio"/>	Other: _____			Endocrine:	Yes	No
ringing in the ears	<input type="radio"/>	<input type="radio"/>	_____			Excessive thirst	<input type="radio"/>	<input type="radio"/>
Noise exposure	<input type="radio"/>	<input type="radio"/>	Genitourinary:	Yes	No	Cold intolerance	<input type="radio"/>	<input type="radio"/>
Nasal obstruction	<input type="radio"/>	<input type="radio"/>	Dialysis	<input type="radio"/>	<input type="radio"/>	Heat intolerance	<input type="radio"/>	<input type="radio"/>
Sinusitis	<input type="radio"/>	<input type="radio"/>	Other: _____			Diabetes	<input type="radio"/>	<input type="radio"/>
Loss of smell	<input type="radio"/>	<input type="radio"/>	_____			Other: _____		
Hoarseness	<input type="radio"/>	<input type="radio"/>	Musculoskeletal:	Yes	No	_____		
Difficulty swallowing	<input type="radio"/>	<input type="radio"/>	Connect tissue disease	<input type="radio"/>	<input type="radio"/>	Hematologic/Lymphatic:	Yes	No
Other: _____			Cervical spine disease	<input type="radio"/>	<input type="radio"/>	Bleeding Problems	<input type="radio"/>	<input type="radio"/>
_____			Other: _____			Anemia	<input type="radio"/>	<input type="radio"/>
Cardiovascular:	Yes	No	_____			Other: _____		
Chest pain	<input type="radio"/>	<input type="radio"/>	Skin:	Yes	No	_____		
Leg swelling	<input type="radio"/>	<input type="radio"/>	Infection	<input type="radio"/>	<input type="radio"/>	Allergy/Immunologic:	Yes	No
Heart murmur	<input type="radio"/>	<input type="radio"/>	Other: _____			Immune deficiency	<input type="radio"/>	<input type="radio"/>
Abnormal heart beat	<input type="radio"/>	<input type="radio"/>	_____			Other: _____		
Heart attack	<input type="radio"/>	<input type="radio"/>				_____		
Other: _____								

Patient/Guardian Signature: _____

Date: _____

