Colorado West Otolaryngologists, PC

2643 Patterson Rd, Suite 503 ◆Grand Junction, CO 81506
970-245-2400 ◆ Fax 970-242-9092

Patient Medical History Form

Confidential Record: Information contained herein will not be released except when you have authorized us to do so.

Referring Doctor _____ Date _____

Name _____ Male/Female DOB _____

Reason For Visit _____

When did problem first appear? _____ Please list name and approximate date of previous treatment for this problem from other practitioners _____

_____

Ear Nose and Throat Questions Please Check all that apply to **the patient**

- ❑ Sore spot or abnormal bump in mouth or throat
- ❑ Dentures
- ❑ Difficulty Swallowing
- ❑ Sensation of a lump in your throat
- ❑ Hoarseness
- ❑ Pain on swallowing
- ❑ Nosebleeds
- ❑ Obstructed breathing through nose
- ❑ Draining Sinus
- ❑ Headaches
- ❑ Mouth or Throat bleeding
- ❑ Recurrent Sinusitis
- ❑ Hay Fever
- ❑ Hearing Loss
- ❑ Ringing in Ears
- ❑ Ear Pain
- ❑ Ear Drainage
- ❑ Dizziness
- ❑ Eye Pain
- ❑ Blind Spots
- ❑ Glaucoma
- ❑ Double Vision
- ❑ Wear hearing aids
- ❑ Wear glasses
- ❑ Wear contacts

Comments: _____

General Health Questions Please Check all that apply to **the patient**

- ❑ Wheezing
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Constant cough
- ❑ Low blood pressure
- ❑ Chest pains
- ❑ Irregular heart beat/Palpitations
- ❑ Urinary infections
- ❑ Heart burn/Acid Reflux (requiring frequent antacids)
- ❑ Colitis
- ❑ Chronic diarrhea
- ❑ Jaundice
- ❑ Pancreatitis
- ❑ Hiatal hernia
- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Trouble opening mouth
- ❑ Limited joint motion
- ❑ Muscle weakness
- ❑ Have you ever had any Neurological problem?
- ❑ Head injury
- ❑ Numbness/Weakness
- ❑ Depression
- ❑ Anxiety Disorder
- ❑ Other Mental Problems
- ❑ Anemia
- ❑ Sickle cell disease/trait
- ❑ Easily bruised
- ❑ Fibromyalgia

Comments: _____

Please circle Drug Allergies and give symptoms of reaction ***Penicillin***_____ ***Sulfa***_____
Codeine_____ ***Latex***_____ ***Iodine***_____ ***None Known***
Other (please list) _____

Children (18 and under)
Immunizations current & up to date? _____ Yes _____ No History of chicken pox? _____ Yes _____ No
Chicken pox vaccine? _____ Yes _____ No

Family History Has a blood relative had:

- ❑ Reaction to anesthesia
- ❑ Bleeding problems
- ❑ Heart disease
- ❑ Diabetes
- ❑ Cancer

Medical Illnesses Please Check all that apply to **the patient**

- ❑ Cancer - what part of the body? _____approximate date of diagnosis? _____
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Emphysema or COPD
- ❑ Diabetes
- ❑ Heart troubles
  - ❑ Heart Attack
  - ❑ Rheumatic Fever
  - ❑ Congestive Heart Failure
  - ❑ Atrial Fibrillation
- ❑ High Blood pressure
- ❑ High cholesterol/triglycerides
- ❑ Stroke
- ❑ Epilepsy/Seizures
- ❑ Ulcers
- ❑ Thyroid disorder _____
  - ❑ Hyperthyroid
  - ❑ Hypothyroid
- ❑ Bleeding problems
- ❑ Kidney Stones
- ❑ Hepatitis – Type _____
  - ❑ Active
  - ❑ Inactive
- ❑ HIV/AIDS
- ❑ Obstructive Sleep Apnea
- ❑ Rheumatoid arthritis
- ❑ Pulmonary Embolus
- ❑ History of Recurrent Leg Blood Clots
- ❑ Neurologic Disorders
  - ❑ Multiple Sclerosis
  - ❑ ALS
  - ❑ Other _____

Surgeries/Hospitalizations:

Please list the name and approximate date of **ALL** previous surgical procedures and serious hospitalizations.(not just ENT related)

Name of Operation	Date	Name of Operation	Date

Has **the patient** ever had a serious reaction to anesthesia? ☐ Yes ☐ No If yes, describe _____
Are You Pregnant? ☐ Yes ☐ No ☐ N/A
Has **the patient** ever had a blood transfusion? ☐ Yes ☐ No When? _____

Social History for the patient

Marital Status ☐ S ☐ M ☐ D ☐ W Do you have children ☐ Yes ☐ No _____

Do you have Pets? ☐ Yes ☐ No If yes, what kind_____

Profession_____

Place an "X" in proper Column	Yes	No		
Do you or have you chewed tobacco?			How long?	Date quit -
Do you or have you ever smoked cigarettes?			How long? How many packs a day?	Date quit -
Do you or have you ever smoked marijuana?			How long? How often?	Date quit -
Do you drink alcohol?			How much per week?	
Do you or have you ever used cocaine or IV drugs?			How often	

Please list ALL medications you are now taking (or attach list if extensive) Please write none if you are not taking any medications

Name	Strength(mg)	Times per day	Name	Strength(mg)	Times per day

Please list your pharmacy of choice for prescriptions. _____

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PATIENT INFORMATION

Patients Last Name	First Name	Middle Initial		
Patients Social Security #	E-mail address			
Mailing Address (Street)	(City,State,Zip)			
Primary Phone	Work Phone	Cell/Other Phone	Sex (Circle One) Male Female	Date of Birth
Referring Physician	Primary Care Physician			
Preferred Language ☐ English ☐ Spanish ☐ Other _____	**Race** ☐ Black or African American ☐ Hispanic ☐ White ☐ Other _____	**Ethnicity**	**How did you learn about our practice?**	

PERSON RESPONSIBLE FOR PAYMENT/TO RECEIVE STATEMENTS (If Different From Patient)

Spouse/Parent Last Name	First Name	Middle Initial	Relationship	Social Security #
Cell/Other Phone	Address (Street, City, State And Zip)			

SPOUSE/PARENT LIVING WITH (If not already listed)

Spouse/Parent Last Name	First Name	Middle Initial	Relationship	Social Security #
Date of Birth	Work Phone		Cell/Other Phone	

EMERGENCY CONTACT PERSON (not living with patient)

Name (First and Last)	Home Phone	Relationship

INSURANCE INFORMATION (must be listed if you want us to bill your insurance)

Primary Insurance Co.	ID#	Group or Plan #	
Insured Party (Subscriber)	**Subscriber's SS#**	**Subscriber's DOB**	**Relationship to patient**
Subscriber's Mailing Address (if different from patient) (Street)		(City,State,Zip)	
Secondary Insurance Co.	ID#	Group or Plan #	
Insured Party (Subscriber)	**Subscriber's SS#**	**Subscriber's DOB**	**Relationship to patient**
Subscriber's Mailing Address (if different from patient) (Street)		(City,State,Zip)	

The information listed above is accurate to the best of my knowledge. I hereby authorize Colorado West Otolaryngologists to disclose all medical records pertaining to me and hereby release Colorado West Otolaryngologists from any liability therefore so long as such records are disclosed in confidence to a hospital, health maintenance organization, managed care organization, health insurance benefit plan, health care entity, professional liability carrier, or peer review body, or the delegated agent of any such entity or body, to verify billing or for the purpose of conducting quality of care review, utilization management review, risk management review, peer review, or other similar activity. I hereby authorize messages regarding appointments with this office to be left on my telephone answering machine or with a family member. I understand that I am ultimately responsible for any of my charges, regardless of insurance coverage. I authorize payment directly to Colorado West Otolaryngologists, P.C. of any benefits payable to me for services rendered.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been advised of the Notice of Privacy Practices for Colorado West Otolaryngologists, P.C.

Signature_____ **Date** _____

Patient/Parent/Legal Guardian