ENT and Allergy Associates of Florida, P.A. – Patient Information

Please Fill Out Form Completely

Salutation/Titular: Mr.___ Mrs.___ Ms.____Miss____ Dr.____

Patient Name: _____

Date of Birth:_____ Age:_____

Sex: F____ M ____ Marital Status: M ___ S___ D ___ W___ Other___

Please check appropriate response:

* *Race: American Indian/Alaska Native_____ Asian_____ Black/African American_____ Declined to answer _____

Native Hawaiian/Pacific Islander_____ Other Race____ White_____

Please check appropriate response:

**Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____

Religion: _____ Primary Language: _____ Maiden Name: _____

Responsible Party/Guarantor Name:_____

Patient's Address:_____

Street City, State Zip

Patient's 2nd Address:_____ _____Full-time _____Part-time Resident

Patient's Phone (Primary) (_____)_____Patient's Phone (Cell) (_____)_____

Please check your preference on how to contact you: Home Phone:___ Cell Phone: ___ Other: _____

Email Address:_____ Employer Name:_____

Emergency Contact:_____Relationship:_____Phone#_____

Whom may we thank for referring you?_____

Referring Physician:_____ Primary Care Physician:_____

Is this visit related to a Work Accident_____ Auto Accident _____ or Other Accident _____

Pharmacy Name_____Address:_____Tele#_____

Insurance Information

Primary Insurance Company:_____ Subscriber's Name:_____

Relationship to Patient:_____Date of Birth:_____ID#_____Group#_____

Secondary Insurance Company:_____ Subscriber's Name:_____

Relationship to Patient:_____ Date of Birth:_____ID#_____Group#_____

I also authorize my Physician and ENT and Allergy Associates of Florida, P.A. to photograph me for medically related documentation purposes.

Signature:_____Date:_____

Ear, Nose and Throat Associates Peter B. McKernan, M.D., D.D.S.
6101 Webb Road, Suite 211, Tampa, FL 33615 Phone: (813) 884-4967 Fax: (813) 889-0847 **ENT-ASSOCIATES.COM**

ENT and Allergy Associates of Florida

Caring For Our Patients Since 1963

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MEDICAL HISTORY FORM

Patient Name:_____ Date of Birth:_____ M or F

Referring Physician: _____

*Pharmacy Name _____

*Pharmacy Cross Street_____

*Pharmacy Phone Number_____

Primary Care Physician:_____ **Weight:**_____ **Height**: _____

Briefly, why are you seeing our physician today? _____

1. **Patient History** - Please check your response

	Yes	No
Cancer (enter details below)	( )	( )
Heart (enter details below)	( )	( )
Cardio: Hypertension	( )	( )
Ear: Dizziness	( )	( )
Ear: Hearing Loss	( )	( )
Ear: Tinnitus/Ringing in Ear	( )	( )
Endocrine: Diabetes	( )	( )
Endocrine: Thyroid Disorders	( )	( )
G.I.: Bowel Disorders	( )	( )

	Yes	No
Nasal: Allergies	( )	( )
Nasal: Nasal Trauma	( )	( )
Nasal: Nose Bleeds	( )	( )
Nasal: Sinusitis	( )	( )
Neuro: Headaches/Migraines	( )	( )
Neuro: Nervous System	( )	( )
Neuro: Seizure Disorder	( )	( )
Ophth: Eyes/Glaucoma	( )	( )
Oral: Sleep Apnea	( )	( )

	Yes	No
G.I.: Liver Disorders	( )	( )
Stomach Disorders/Ulcer	( )	( )
Reflux/GERD/Heartburn	( )	( )
Immuno: HIV	( )	( )
Immune Disease	( )	( )
Lymph: Anemia	( )	( )
Bleeding Disorders	( )	( )

	Yes	No
Psychiatric Disorders	( )	( )
Pulmonary: Lungs	( )	( )
Tuberculosis	( )	( )
Urology: Bladder	( )	( )
Kidneys	( )	( )
	( )	( )
	( )	( )

Other: _____

Details of Yes answers:_____

_____

_____

_____

_____

_____

2. **Surgeries** - Please list any surgeries/hospitalizations: _____

_____

3. **Social History -** Are you a current smoker? (Y or N) You now smoke_____packs of cigarettes a day.

4. You smoked_____packs per day and quit_____years ago.

You consume_____alcoholic beverages per day / week / month (circle).

How many caffeinated beverages (8ounces) do you drink per day? _____

5. **Family History -** Please check your response

	Yes	No		Yes	No
Allergies	( )	( )	Premature Hearing Loss	( )	( )
Cancer	( )	( )	Sinusitis	( )	( )
Diabetes	( )	( )	Sleep Apnea	( )	( )
Headaches/Migraine	( )	( )	Thyroid Disorders	( )	( )
Immune Disease	( )	( )			

Details of Yes answers:_____

_____

_____

Patient Signature:_____ **Date**: _____

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www.entaaf.com

Place label here/or patient full name/account number

ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

☐ No Known Drug Allergies

MEDICATIONS: Date: _____ Reconciled by:_____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response: ☐ Yes ☐ No**

Patient/Guardian Signature: _____

Print Patient Name: _____ D.O.B:_____