NORTH ATLANTA EAR, NOSE & THROAT ASSOCIATES

North Atlanta Sinus and Sleep Center
Breathe easy, live well

ACCT # _____

NEW PATIENT QUESTIONNAIRE

NAME: _____ **DOB:** _____ **Todays Date** _____

INFORMANT: ☐Patient ☐Parent ☐Other **REFFERING PHYSICIAN:** _____
PREFERRED PHARMACY AND NUMBER: _____

Have any family members been seen in our office previously? ☐Yes ☐No Name: _____

REASON FOR APPOINTMENT (include location, severity, what time of day, duration of symptoms, modifying factors, associated signs/symptoms):

Current Medications: (include dosage and frequency if known)

Prescription	Over the Counter	Vitamins/Supplements

Drug Allergies:

Chronic or Past Medical Problems: None ☐

☐ Asthma	☐ Emphysema	☐ Hepatitis (Type if known)
☐ Hayfever, Nasal Allergies	☐ COPD	☐ Other Liver Disease
☐ Sinus Problems	☐ Sarcoidosis	☐ High Blood Pressure
☐ Eczema	☐ Other Lung Disease	☐ High Cholesterol and/or Triglycerides
☐ Hives	☐ Immunodeficiency	☐ Other Heart Disease
☐ Angioedema/Anaphylaxis	☐ AIDS	☐ Stroke
☐ Latex Allergy	☐ Psoriasis	☐ Seizures/Epilepsy
☐ Insect Sting Allergy	☐ Diabetes ☐Type 1 ☐Type 2	☐ Migraine Headaches
☐ Food Allergy	☐ Kidney Disease	☐ Eosinophilic Esophagitis
☐ Rheumatoid Arthritis	☐ Thyroid Disease	☐ Crohn's Disease
☐ Lupus	☐ Glaucoma	☐ Ulcerative Colitis
☐ Other Autoimmune Disease	☐ Epistaxis	☐ GERD
☐ Osteoarthritis	☐ Blood Clotting Disorder	☐ Barrett's Esophagitis
☐ Osteoporosis	☐ Cancer – Type:	☐ Psychiatric Disease – Type:

Other Serious or Chronic Medical Problems: ☐None

Tobacco Use: (Age 13 and over) Cigarettes ☐ Never ☐Former Smoker # of years_____ Avg. # per day_____ Year Stopped_____
☐Current Smoker # of years_____ Avg. # per day _____

Other Tobacco ☐Former ☐Current Second Hand Smoke Exposure ☐

Alcohol Use: ☐None # of drinks per day_____ per week_____ **Recreational Drug Use:** ☐None ☐Marijuana ☐Other

PAST SURGERIES/HOSPITALIZATIONS: (include year if known) **NONE** ☐

NAME: _____ **ACCT # _____**

FAMILY HISTORY:

	Heart disease	Asthma	Cancer	Allergy	Other Conditions
Mother ☐Living ☐ Deceased					
Father ☐Living ☐ Deceased					
Sibling #Living ____ #Deceased ____					
Child #Living ____ #Deceased ____					
Other					

SYMPTOMS/PROBLEMS: Do you CURRENTLY have or have you RECENTLY had any of the following?

GENERAL ☐Fatigue ☐Fever ☐Sweats ☐Weight Gain ☐Weight Loss ☐Difficulty Sleeping

EYES ☐Itching ☐Redness ☐Watering ☐Dryness ☐Other

EARS ☐Pain ☐Plugged ☐Itching ☐Ringing ☐Recurrent Infections ☐Tubes ☐Other

NOSE/SINUSES/THROAT ☐Runny Nose ☐Postnasal Discharge ☐Stuffiness ☐Sneezing ☐Nose Bleeds ☐Nasal Polyps ☐Loss of Smell or Taste ☐Snoring ☐Sinus Pressure ☐Sinus Headache ☐Past Sinus or Nose Surgery ☐Sore Throat ☐Itchy Throat ☐Hoarseness ☐Difficulty Swallowing ☐Throat Clearing ☐Other

LUNGS ☐Productive Cough ☐Non-Productive Cough ☐ Wheezing ☐Chest Tightness ☐Shortness of Breath ☐Difficulty breathing with exercise ☐Recurrent Bronchitis ☐Recurrent Pneumonia ☐Other

SKIN ☐Itching ☐Eczema ☐Hives ☐Psoriasis ☐Other Rash ☐Allergy Swelling/Angioedema ☐Other

GASTROINTESTINAL/DIGESTIVE ☐Bloating ☐Abdominal Pain ☐Constipation ☐Diarrhea ☐Vomiting ☐Heartburn/Indigestion ☐Other

BLOOD/LYMPH ☐Lymph Node Swelling ☐Anemia ☐Other

HEART ☐Chest Pain ☐Fast or Irregular Heart Rate ☐Fainting ☐Swelling of ankles/feet ☐ Heart Murmur ☐ Other

MUSCULOSKELETAL ☐ Joint Swelling ☐Joint Pain ☐Muscular Pain ☐Back Pain ☐Other

ENDOCRINE ☐Cold Intolerance ☐Unusual Hair Loss ☐Excessive Thirst ☐ Rapid Weight Change ☐ Other

GENITOURINARY ☐Painful or Frequent Urination ☐Frequent Urinary Infections ☐ Other
For Women: ☐Currently pregnant ☐Menopausal For Men: ☐ Prostate Problems

NEUROLOGIC ☐Headaches ☐Seizures ☐Memory Loss ☐Learning Problems ☐Other

PSYCHIATRIC ☐Depression ☐Anxiety ☐Mood Swings ☐Agitation ☐Other

Please describe any other concerns regarding your health:

ENVIRONMENTAL allergy history /SOCIAL HISTORY:

Home: ☐House ☐Townhouse ☐Condo ☐Apartment ☐Mobile Home

Years in Georgia: _____ ☐Native **Years in Current Home**: _____ Age of Home_____

Heating System: ☐Forced Air ☐ Hot Water Baseboard ☐Other **Air Conditioning:** ☐None ☐Central ☐Window/Wall AC ☐Evaporative Cooler

Flooring: Living area ☐Carpet ☐Wood/Tile etc. ☐Wool Area Rug
Bedroom ☐Carpet ☐Wood/Tile etc. ☐Wool Area Rug
Basement ☐Cement ☐ Subfloor ☐Carpet ☐Wood/Tile etc. ☐Crawl Space

Mattress/Bedding: ☐ Spring ☐Foam/Latex ☐Air/Water Age of mattress _____
☐Down pillows ☐ Down Comforter ☐ Down Mattress Topper

Pets: ☐None Dogs # _____ Cats# _____ Other _____

Do you suspect any home or work exposures are triggering symptoms? ☐Yes ☐No

Occupation: _____

Type of Workplace: _____

School: _____

PATIENT/PARENT SIGNATURE: _____