NORTH ATLANTA ENT & ALLERGY

New Patient Questionnaire

ACCT # _____

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:

	Hearing loss	Asthma	Apnea	Sinusitis	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 ☐ PainPlugged ☐ 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

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: _____

4150 Deputy Bill Cantrell Memorial Dr. Suite #260 Cumming, GA 30040
o:770.292.3045 • f: 770.292.3046 • naenta2012@gmail.com • naenta.com