Name:_____
DOB:_____
MRN:_____

Date: _____ / _____ / _____

**Medical College of Virginia Hospitals**
**Virginia Commonwealth University**
**Richmond, Virginia 23298**
**Department of Otolaryngology - Head & Neck Surgery**

# INITIAL PATIENT VISIT

PLEASE TAKE A MOMENT TO COMPLETE THE FOLLOWING FOR OUR RECORDS

| | |
|---|---|
| Primary Care Physician: | Telephone Number: |
| Referring Physician: | Telephone Number: |
| *For patients under 18 years old:*<br>Mother's Name:<br>Father's Name: | <br>Daytime Telephone Number:<br>Daytime Telephone Number: |

Pediatric Patients: Daycare: ☐ Y ☐ N Educational Situation:

Reason for visit: _____

_____

Other/Past Medical Problems: _____

_____

Past Surgery or Hospitalizations (with dates): _____

_____

Current Medications (with doses if possible): _____

_____

Allergies to Medications: _____

Immunization Up-to-date:_____

Smoking: Patient: ☐ Y ☐ N Packs per day: ☐ ½ ☐ 1 ☐ 2 Quit when? _____
In the home ☐ Y ☐ N ☐ Light ☐ Moderate ☐ Heavy

Alcohol: Drink Alcohol? ☐ Y ☐ N_____Drinks per day_____Quit when? _____

Occupation:_____ Retired when?_____

Who lives in the home: _____

Illnesses that run in the family: ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Other

Have you / your child had any of the following (check Y or N): Abnormal Findings

| | | | | | | |
|---|---|---|---|---|---|---|
| *Const* | Weight loss (unplanned) | ☐ Y ☐ N | *Heme* | Easy bruising | ☐ Y ☐ N | |
| | Recent fevers/chills | ☐ Y ☐ N | | Prolonged bleeding | ☐ Y ☐ N | |
| *Derm* | Facial rashes | ☐ Y ☐ N | | Hemophilia in family | ☐ Y ☐ N | |
| | Skin cancers | ☐ Y ☐ N | *Eye* | Glaucoma | ☐ Y ☐ N | |
| *Resp* | Chronic cough | ☐ Y ☐ N | | Vision changes | ☐ Y ☐ N | |
| | Coughing blood | ☐ Y ☐ N | *Neuro* | Recurrent headaches | ☐ Y ☐ N | |
| | Asthma | ☐ Y ☐ N | | Facial numbness | ☐ Y ☐ N | |
| *Card* | Heart attack | ☐ Y ☐ N | | Seizures | ☐ Y ☐ N | |
| | Chest Pains | ☐ Y ☐ N | *GI* | Ulcers | ☐ Y ☐ N | |
| | Heart murmur | ☐ Y ☐ N | | Heartburn | ☐ Y ☐ N | |
| | Foot/ankle swelling | ☐ Y ☐ N | *Endo* | Diabetes | ☐ Y ☐ N | |
| *GU* | Painful urination | ☐ Y ☐ N | | Thyroid disease | ☐ Y ☐ N | |
| | Blood in urine | ☐ Y ☐ N | *Skel* | Arthritis | ☐ Y ☐ N | |

Other:_____

Name:_____
DOB:_____
MRN:_____

Date: _____ / _____ / _____

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# INITIAL PATIENT VISIT

PLEASE CHECK ANY OF THE PROBLEMS BELOW THAT BOTHER YOU ON A REGULAR BASIS

Nose or Sinus Problems:

- ☐ Runny nose
- ☐ Post nasal drip
- ☐ Headaches
- ☐ Facial swelling
- ☐ Decreased sense of smell or taste

Abnormal Findings:

- ☐ Allergies
- ☐ Blocked nose
- ☐ Nasal or facial pain
- ☐ Bloody noses
- ☐ Appearance of nose

Ear / Hearing / Balance Problems:

- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Wax buildup
- ☐ Lightheadedness
- ☐ Hearing noises (tinnitus)
- ☐ Ear discharge
- ☐ Ear infections
- ☐ Vertigo

Throat Problems:

- ☐ Frequent sore throats
- ☐ Trouble swallowing solids
- ☐ Pain swallowing
- ☐ Change in voice or speech
- ☐ Noisy breathing
- ☐ Loud snoring
- ☐ Neck pain
- ☐ Tonsillitis
- ☐ Trouble swallowing liquids
- ☐ Coughing after swallowing
- ☐ Difficulty breathing
- ☐ Acid reflux
- ☐ Lump in neck

Other:_____

I believe the above information to be complete to the best of my knowledge.

Patient Signature: _____ Date: _____

Reviewed with Patient by: _____ M.D. Date: _____