

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:

<i>For patients under 18 years old:</i> Mother's Name:	Daytime Telephone Number:
Father's Name:	Daytime Telephone Number:

Pediatric Patients: Daycare: <input type="checkbox"/> Y <input type="checkbox"/> 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: <input type="checkbox"/> Y <input type="checkbox"/> N	Packs per day: <input type="checkbox"/> ½ <input type="checkbox"/> 1 <input type="checkbox"/> 2	Quit when? _____
	In the home <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	

Alcohol:	Drink Alcohol? <input type="checkbox"/> Y <input type="checkbox"/> 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
<i>Const</i>	Weight loss (unplanned)	<input type="checkbox"/> Y <input type="checkbox"/> N	<i>Heme</i> Easy bruising	<input type="checkbox"/> Y <input type="checkbox"/> N
	Recent fevers/chills	<input type="checkbox"/> Y <input type="checkbox"/> N	Prolonged bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>Derm</i>	Facial rashes	<input type="checkbox"/> Y <input type="checkbox"/> N	<i>Eye</i> Hemophilia in family	<input type="checkbox"/> Y <input type="checkbox"/> N
	Skin cancers	<input type="checkbox"/> Y <input type="checkbox"/> N	<i>Neuro</i> Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>Resp</i>	Chronic cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Vision changes	<input type="checkbox"/> Y <input type="checkbox"/> N
	Coughing blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Recurrent headaches	<input type="checkbox"/> Y <input type="checkbox"/> N
	Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Facial numbness	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>Card</i>	Heart attack	<input type="checkbox"/> Y <input type="checkbox"/> N	<i>GI</i> Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
	Chest Pains	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
	Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	<i>Endo</i> Heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N
	Foot/ankle swelling	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>GU</i>	Painful urination	<input type="checkbox"/> Y <input type="checkbox"/> N	<i>Skel</i> Thyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> N
	Blood in urine	<input type="checkbox"/> Y <input type="checkbox"/> N	Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Other: _____				

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 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: _____