|  |  |
| --- | --- |
|  | **1434 Chester Boulevard****Richmond, Indiana 47374****765-966-1600 tele / 765-962-9641 fax** |

**PATIENT HISTORY – New Reid Ent Pt/New RPA Pt**

❑ Dr. Bawa ❑ Dr. Peers ❑ Dr. Bauer ❑ Dr. Casselman ❑ Kristy Carter PA-C

Patient Name: Date of Visit:

Date of Birth: Age:

Height: Weight:

Primary Care Provider:

Referring Provider:

Reason for your office visit today:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| When did your problem(s) start?  |  Days |  Weeks |  Months |  Years |  |
|  | * Sudden
 | * Gradual
 | * Ongoing
 | * Since Birth
 | * Unknown
 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How long does each episode last?  | * <1 min
 | * 1-4 min
 | * 5-10 min
 | * 15-30 min
 | * 30-60 min
 |
|  | * Hours
 | * Days
 | * Weeks
 | * Months
 | * Years
 |
|  | * Intermittently
 | * Constantly
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| What is the "severity" of your symptoms? | * Mild
 | * Moderate
 | * Severe
 | * Other
 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| What is the current status? | * Improving
 | * Unchanged
 | * Worsening
 | * Resolved
 | * Other
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| If you are having pain, describe pain:  | * Sharp
 | * Dull
 | * Burning
 | * Throbbing
 |
|  | * Aching
 | * None
 |  |  |

**TESTING DONE TO EVALUATE CURRENT PROBLEM**

* CT Scan (type where/date )
* MRI (type where/date )
* Ultrasound (type where/date )
* Allergy testing (type where/date )
* Breathing tests (type where/date )
* Other (type where/date )

**MEDICATIONS**

|  |  |
| --- | --- |
| **List current medications (including supplements) and dosage.** | * **NONE**
 |

|  |  |  |
| --- | --- | --- |
| **Medication** |  | **Dosage** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ALLERGIES TO MEDICATIONS**

|  |  |
| --- | --- |
| **List drug allergies & reactions.** | * **NONE**
 |

|  |  |  |  |
| --- | --- | --- | --- |
| * Aspirin
 | * Codeine
 | * Penicillin
 | * Sulfa
 |
| * Latex
 | * Adhesive Tape
 |  |  |
| * Other
 |  |  |  |

**MEDICAL CONDITIONS**

|  |  |
| --- | --- |
| **Do you now have or have you ever had any of the following?** | * **NONE**
 |

|  |  |  |
| --- | --- | --- |
| * Alcoholism/Drug Addiction
 | * Depression
 | * Liver Disease
 |
| * Allergies
 | * Diabetes
 | * Neurologic Disorder
 |
| * Anemia
 | * GERD/Reflux
 | * Psychiatric Treatment
 |
| * Arthritis
 | * Heart Disease (type )
 | * Seizures/Epilepsy
 |
| * Asthma
 | * Hepatitis
 | * Sleep Apnea
 |
| * Bleeding Disorder
 | * High Blood Pressure
 | * Stroke
 |
| * Cancer (type )
 | * Kidney Disorder
 | * Thyroid Disease
 |
| * COPD/Emphysema
 |  |  |

Other problems not listed, recent hospitalization, or details about above listed problems:

**PROCEDURE HISTORY**

|  |  |
| --- | --- |
| **Check the procedure(s) you have had and write the date(s) performed.** | * **NONE**
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Procedure** | **Date** |  | **Procedure** | **Date** |
| * Angioplasty/Stent
 |  |  | * Hip Replacement
 |  |
| * Appendectomy
 |  |  | * Hysterectomy
 |  |
| * Arthroscopic Knee
 |  |  | * Knee Replacement
 |  |
| * Back Surgery
 |  |  | * LASIK
 |  |
| * Carpal Tunnel
 |  |  | * Pacemaker
 |  |
| * Cataract
 |  |  | * Sinus/Nasal Surgery
 |  |
| * Colon Surgery
 |  |  | * Thyroidectomy
 |  |
| * Ear Tubes
 |  |  | * Tonsillectomy
 |  |
| * Gallbladder Removal
 |  |  | * Adenoidectomy
 |  |
| * Gastric Bypass
 |  |  | * Tubal Ligation
 |  |
| * Heart Bypass
 |  |  | * Vasectomy
 |  |
| * Hernia
 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Other (date/list)
 |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**FAMILY HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Relationship** |  |  | **Relationship** |
| * Cancer (type )
 |  |  | * Heart Disease
 |  |
| * Diabetes
 |  |  | * Kidney Disease
 |  |
| * Hearing Loss
 |  |  | * Liver Disease
 |  |
| * Other
 |  |  |  |  |

**SOCIAL HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Smoking/Smokeless Tobacco History**  | * Current
 | * Former
 | (When did you quit? ) | * Never
 |

If yes, in what form & how much? How many years?

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you drink alcohol?**  | * Yes
 | * No
 | * Quit
 |

If yes, in what form & how much?

**PHARMACY INFORMATION**

Name

Address

Phone

Mail Order Pharmacy

Signature of Patient or Guardian Date

Signature of Reid ENT Specialist Date