|  |  |
| --- | --- |
|  | **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