SOUTHWEST IDAHO
ENT
Ear Nose and Throat, P.A.

To our new patients:

Welcome to Southwest Idaho Ear Nose and Throat. Our physicians strive to provide the best possible care for all patients, and part of this process is obtaining accurate demographic and health history information. In order to expedite the check-in process for your appointment, we have included the necessary forms for you to complete in advance.

Please fill out your paperwork completely and bring it with you to your appointment, arriving 15 minutes early. If desired, you may fax your paperwork to our office at **(208) 367-3979** prior to your appointment. Your insurance cards will be required at check-in, and we encourage you to find and submit the most recent copy of your card. This includes Medicare and Medicaid as well. If your insurance plan (including Medicaid) requires a referral, please follow up to ensure that it is in our office so that your appointment will not need to be rescheduled. Financially, payment will be required at the time of service for your portion (co-pay and deductible amounts) of the charges.

Please feel free to contact our office with any questions you may have. Our physicians and staff look forward to caring for you and your family. Thank you for choosing Southwest Idaho Ear Nose and Throat.

SOUTHWEST IDAHO ENT
Ear Nose and Throat, P.A.

PHH Adult

Patient's Name: _____ D.O.B. _____

Referring Physician: _____

For Women: Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly / Not Sure

Name and location of pharmacy used: _____

What are you seeing the doctor for today? _____

List all current medications, including any over-the- counter (OTC) medications or supplements.
(If needed, please provide on separate sheet.)
☐ Not taking any medications

NAME OF MEDICATION	DOSAGE

List any drug allergies or medicines you can not take
☐ No known drug allergies

NAME OF MEDICATION	TYPE OF REACTION

Do you have a known allergy to any of the following? ☐ None

☐ Latex ☐ Iodine ☐ Tape ☐ Contrast Agents (Dye) ☐ Other (Please describe) _____

Describe reaction _____

Allergies
☐ None
☐ Dust
☐ Moldy Places
☐ Pollen
☐ Cut Grass
☐ Animals
☐ Foods
☐ Smoke / Fumes
☐ Outside in Spring and/or Fall
☐ Outside on Windy Days
☐ Air Conditioning

Allergy Testing
☐ Never Done
☐ Skin / Blood
☐ Negative
☐ Testing Location
_____

Allergy Injections
☐ Never Done
☐ In the Past
☐ Currently

Other Allergies/Problems Not Listed
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
_____
_____
_____
Please Describe

900 N. Liberty St., Suite #400, Boise, ID 83704 • www.swient.com • (208) 367-3320

Past Health History

Please indicate any diseases or problems that you have had or been diagnosed with by a doctor

☐ **No Major Illnesses**

1. Childhood Diseases
- ☐ Mumps
- ☐ Measles
- ☐ Chicken Pox
- ☐ Other _____

2. Cancer
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Skin Cancer
- ☐ Leukemia
- ☐ Other _____

3. Congenital (Birth) Problems
- ☐ Down Syndrome
- ☐ Heart Defect
- ☐ Prematurity (# of weeks ____)
- ☐ Other _____

4. Ears
- ☐ Chronic or Frequent Infection
- ☐ Fluid
- ☐ Hearing Loss
- ☐ Vertigo
- ☐ Other _____

5. Nose and Sinuses
- ☐ Chronic Sinusitis
- ☐ Deviated Septum
- ☐ Nasal Polyps
- ☐ Allergies
- ☐ Other _____

6. Mouth and Throat
- ☐ Chronic Tonsillitis
- ☐ Cleft Palate
- ☐ Sleep Apnea
- ☐ Other _____

7. Heart
- ☐ Atrial Fibrillation
- ☐ Chest Pain / Angina
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Pace Maker
- ☐ Other _____

8. Lungs
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Cystic Fibrosis
- ☐ Other _____

9. Digestive
- ☐ GERD / Reflux
- ☐ Hepatitis Diverticulitis
- ☐ Hemorrhoids
- ☐ Other _____

10. Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Other _____

11. Neurologic
- ☐ Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Other _____

12. Glands & Hormones
- ☐ Diabetes
- ☐ Thyroid Problem
- ☐ Other _____

13. Blood Disorder
- ☐ Low White Blood Cell Bleeding Disorder
- ☐ Anemia
- ☐ Low Platelets
- ☐ Other _____

14 Immune Disorder
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's
- ☐ CREST
- ☐ HIV
- ☐ Other _____

15. Psychiatric History
- ☐ Depression
- ☐ Anxiety
- ☐ Mania
- ☐ Schizophrenia
- ☐ Other_____

History of any other condition not listed?

_____

Surgeries / Injury

Have you ever had problems with anesthesia (being put to sleep for surgery)? ☐ No ☐ Yes What problem _____

Indicate any major surgeries (if you choose OTHER please describe)

☐ *No Surgery*

Eyes	☐ Cataract ☐ Eyelid ☐ Surgery ☐ Tear ☐ Duct ☐ LASIK ☐ Other:
Ears	☐ Tubes ☐ Ear ☐ Drum ☐ Mastoid ☐ Other:
Nose	☐ Septoplasty ☐ Rhinoplasty ☐ Sinus ☐ Surgery ☐ Other:
Throat	☐ Adenoidectomy ☐ Tonsillectomy ☐ Other:
Neck	☐ Thyroidectomy
Heart	☐ Angioplasty ☐ Bypass ☐ Valve ☐ Stent ☐ Other:
Digestive	☐ Appendectomy ☐ Gallbladder ☐ Hiatal ☐ Hernia ☐ Other:
Female Health	☐ Hysterectomy ☐ Ovary ☐ Removal ☐ Other:
Other	☐ Any other major surgery:

Serious injury? ☐ No ☐ Yes Please Describe: _____

Family History

Do any of your BLOOD RELATIVES have a history of:

☐ Problems with Anesthesia
☐ Hearing Loss After Age 20
☐ Hearing Loss After Age 20
☐ Heart Problem
☐ Cancer
☐ Other Major Health Problems
Please Describe _____
☐ No Family History Problems Known
☐ Family History Unkown

Social History

Current Occupation: _____ ☐ Retired ☐ Student

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Quit ☐ Yes: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew

How many per day? _____

When did you start? Age: _____ or Year:_____ When did you stop? Age: _____ or Year: _____

Alcohol Use: ☐ Yes ☐ No

How many drinks per week on average? _____

Have you ever been dependent on or addicted to any drugs? ☐ Yes ☐ No

Patient Name: _____ Date of birth: _____

Tests and Immunizations

If you are not sure of the exact date of the test/procedure/immunization (month and day are not necessary), please list at least the year to the best of your recollection.

1. If you are a female patient between the ages of 24-64, when was your most recent cervical cancer screening (pap test)?
   N/A or date: _____

2. If you are a female patient between the ages of 42-69, when was your most recent breast cancer screening (mammogram)?
   N/A or date: _____

3. If you are a patient between the ages of 50-75, when was your most recent colorectal cancer screening (Colonoscopy, Sigmoidoscopy or FOBT)? N/A or date: _____

4. If you are a patient 65 years or older, when was your most recent pneumonia vaccination administered?
   N/A or date: _____

5. If you are a patient 6 months and older, when was your most recent influenza immunization administered?
   N/A or date: _____

Patient Signature: _____ Date: _____

Review of Systems/Symptoms

Please indicate any other symptoms that your child has now or has had in the RECENT past.

General
- ☐ None
- ☐ Fever
- ☐ Sleeping Problems
- ☐ Unintentional Weight Loss

Allergy Symptoms
- ☐ None
- ☐ Dust
- ☐ Moldy Places
- ☐ Pollen
- ☐ Cut Grass
- ☐ Animals
- ☐ Foods
- ☐ Smoke / Fumes
- ☐ Outside in Spring and/or Fall
- ☐ Outside on Windy Days
- ☐ Air Conditioning

Allergy Testing
- ☐ Never Done
- ☐ Skin Blood
- ☐ Negative
- ☐ Testing Location

_____

Allergy Injections
- ☐ Never Done
- ☐ In the Past
- ☐ Currently

Other Allergies / Problems Not Listed
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

_____
_____
_____

Please Describe

Facial / Eye Problems
- ☐ None
- ☐ Headaches
- ☐ Facial Pain
- ☐ Facial Weakness
- ☐ Vision Changes Not Corrected by Glasses
- ☐ Other Facial or Eye Problems:

_____

Please Describe

Ear Problems
- ☐ None
- ☐ Ear Pain
- ☐ Ear Drainage
- ☐ Hearing Loss
- ☐ Infection
- ☐ Pressure
- ☐ Dizziness
- ☐ Ringing in Ears (Tinnitus)
- ☐ Other Ear Problems:

_____

Please Describe

Nose Problems
- ☐ Nasal Obstruction
- ☐ None
- ☐ Nasal Congestion
- ☐ Bleeding from Nose
- ☐ Sinus Drainage
- ☐ Other Nose Problems:

_____

Please Describe

Mouth Problems
- ☐ None
- ☐ Voice Change / Hoarseness
- ☐ Loud Snoring
- ☐ Sore Throat
- ☐ Trouble Swallowing
- ☐ Other Mouth Problems:

_____

Please Describe

Neck Problems
- ☐ None
- ☐ Neck Mass
- ☐ Other Neck Problems:

_____

Please Describe

Heart Problems
- ☐ None
- ☐ Chest Pain
- ☐ Lightheadedness
- ☐ Other Heart Problems:

_____

Please Describe

Lung Problems
- ☐ None
- ☐ Frequent Cough
- ☐ Difficulty Breathing
- ☐ Other Lung Problems:

_____

Please Describe

Stomach / GI Problems
- ☐ None
- ☐ Abdominal Pain
- ☐ Heart Burn / Indigestion
- ☐ Other Stomach / GI Problems:

_____

Please Describe

Urinary or Female Health Problems
- ☐ None
- ☐ _____

Please Describe

Bone / Muscle Problems
- ☐ None
- ☐ Painful Joints
- ☐ Other Bone / Muscle Problems:
- ☐ _____

Please Describe

Breast or Skin Problems
- ☐ None
- ☐ _____

Please Describe

Brain or Nerve Problems
- ☐ None
- ☐ Change in Smell
- ☐ Change in Taste
- ☐ Numbness
- ☐ Weakness
- ☐ Other Brain or Nerve Problems:

_____

Please Describe

Blood or Lymph Problems
- ☐ None
- ☐ Excessive Bleeding
- ☐ Other Blood or Lymph Problems:

_____

Please Describe

Immune Problems
- ☐ None
- ☐ Unusual Infections
- ☐ Other Immune Problems:

_____

Please Describe

Other Medical Problems Not Listed
- ☐ _____
- ☐ _____
- ☐ _____

Cardiologist _____

_____
_____
_____

Please Describe