PATIENT REGISTRATION

(Please Print)

PATIENT'S NAME: _____ BIRTHDATE _____

LAST FIRST MIDDLE

ADDRESS: _____

STREET CITY, STATE ZIP CODE

PHONE _____

HOME CELL (if preferred)

EMPLOYER: _____ WORK PHONE: _____

PHARMACY MOST COMMONLY USED: _____

MALE _____ FEMALE _____

MARITAL STATUS _____ SPOUSE'S NAME _____

SOCIAL SECURITY NUMBER _____

IF SINGLE AND UNDER 21:

FATHER'S NAME: _____ EMPLOYED BY: _____

MOTHER'S NAME: _____ EMPLOYED BY: _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

INSURANCE INFORMATION: Our receptionist will scan your insurance card for you.

HOLDER OF INSURANCE _____

RELATION TO PATIENT _____ DATE OF BIRTH _____

EAR, NOSE AND THROAT ASSOCIATES OF BUTLER, LTD.
PATIENT HEALTH QUESTIONNAIRE
REVIEW OF SYSTEMS/PFSH
(TO BE UPDATED ONCE YEARLY)

PATIENT NAME_____AGE _____VISIT DATE _____

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? __ YES __ NO IF YES, PLEASE LIST **OR** GIVE YOUR LIST TO THE RECEPTIONIST TO COPY.

_____

LATEX ALLERGY: __ YES __ NO

DO YOU **TAKE** ANY **PRESCRIPTION** MEDICATIONS REGULARLY? __YES __ NO IF YES, PLEASE LIST **OR** GIVE YOUR LIST TO THE RECEPTIONIST TO COPY.

_____

_____

DO YOU TAKE ASPIRIN, NSAID, ARTHRITIS MEDICINE, COUMADIN, PLAVIX: __YES __ NO

DO YOU USE ANY TOBACCO PRODUCTS? __ YES __ NO HOW LONG? _____
HOW MUCH PER DAY? _____ QUIT HOW MANY YEARS AGO? _____

DO ***YOU*** SUFFER FROM ANY OF THE FOLLOWING PROBLEMS? (CHECK FOR YES ONLY)

__RHEUMATIC FEVER
__HEPATITIS
__HEART DISEASE
__LUNG DISEASE
__KIDNEY PROBLEMS
__THYROID DISEASE
__CANCER
__OTHER_____

__DIABETES
__HYPERTENSION
__ASTHMA
__HAY-FEVER
__OSTEOPOROSIS
__MIGRAINES
__MELANOMA

__BLEEDING DISORDER
__REACTION TO ANESTHESIA
__GLAUCOMA
__EPILEPSY/SEIZURES
__HEARING LOSS
__PSYCHIATRIC DISORDER
__CHRONIC EAR INFECTIONS
__NONE

DO YOUR ***PARENTS, BROTHERS AND/OR SISTERS*** SUFFER FROM ANY OF THE FOLLOWING PROBLEMS? (CHECK FOR YES ONLY)

__RHEUMATIC FEVER
__HEPATITIS
__HEART DISEASE
__LUNG DISEASE
__KIDNEY PROBLEMS
__THYROID DISEASE
__CANCER
__OTHER_____

__DIABETES
__HYPERTENTION
__ASTHMA
__HAY-FEVER
__OSTEOPOROSIS
__MIGRAINES
__MELANOMA

__BLEEDING DISORDER
__REACTION TO ANESTHESIA
__GLAUCOMA
__EPILEPSY/SEIZURES
__HEARING LOSS
__PSYCHIATRIC DISORDER
__CHRONIC EAR INFECTIONS
__NONE

PLEASE LIST ANY PREVIOUS SURGERIES:
__NONE

_____

_____