

Adult

Albany ENT & Allergy Services

400 Patroon Creek Boulevard, Suite 205
Albany, New York 12206

Patient Health Care Survey

Patients Age 13 and Above

518 701 2000

Patient Name			Date of Birth	Social Security #
Street Address		City, State and Zip		Email Address
Home Phone	Work Phone	Cell Phone	Preferred Contact Number <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell	
Employer		Employer Phone	Type of Work: <input type="radio"/> Indoors <input type="radio"/> Outdoors <input type="radio"/> Heavy Lifting Mark all that apply <input type="radio"/> Phone (50%) OR MORE <input type="radio"/> Standing (50% OR MORE) <input type="radio"/> Dust or Chemical Exposure <input type="radio"/> Exposure to Loud Noise	

Gender Male Female

Marital Status Single Married Divorced

Ethnicity Non Latino- Hispanic Latino -Hispanic

Preferred Language (if other than English)

Race American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Island
 White More than 1 Race Unknown/Not Reported

Name of Emergency Contact	Relationship	Phone Number	How did you hear about our office:
---------------------------	--------------	--------------	------------------------------------

Complete this section if someone other than you is financially responsible.

Guarantor's Name	Relation to Patient	Date of Birth	Phone Number
Address			City State and Zip

Are you covered by Insurance? Yes No

Does Your Primary Insurance have a Deductible? Yes No If Yes, Has the deductible been met for the current year? Yes No

Please list all medical coverages for which you are eligible below. Use back of page if needed).

Primary Insurance Name	Primary Insurance Policy #	Group #	Co-Pay Office	Co-Pay Tests
Primary Insurance Policy Holder		Policy Holder Date of Birth	Relation to Patient	
Secondary Insurance Name	Secondary Insurance Policy #	Group #	Co-Pay Office	Co-Pay Tests
Secondary Insurance Policy Holder		Policy Holder Date of Birth	Relation to Patient	

Please List other Medical Providers you are seeing currently:

Primary Care Physician Name	PCP Phone	Provider 2 Name	Provider 2 Phone
Provider 3 Name	Provider 3 Phone	Provider 4 Name	Provider 4 Phone

Would you like access to our confidential website to access billing statements, appointment and medication requests? Yes No
If Yes, would you like your billing statements sent: By Email By Mail

Were you referred to our office by: Emergency Room Primary Care Other _____

Is your visit today related to a No Fault, Worker's Compensation or Disability Injury? Yes No

Is your visit today about an injury that related to: Motor Vehicle Accident Accident at Work Altercation

Assignment & Release:

I hereby authorize my insurance benefits to be paid directly to Albany ENT & Allergy Services PC and acknowledge that I am financially responsible for appropriate deductibles, copayments and non-covered items, including those charges which have been denied by my insurance carrier. I understand it is my responsibility to verify with my insurance plan that medical services provided by Albany ENT & Allergy Services will be covered by my plan. I also authorize the release of any information acquired in the course of my examination or treatment to my insurance company and health care provider(s) in accordance with HIPAA guidelines.

Signature of Patient or Guarantor: _____ **Date:** _____

Past Medical & Surgical History

Allergy/Immunology NONE, IF CHECKED SKIP TO NEXT SECTION

Allergies - Not Related to Medication Yes No

If yes, please check or all list below

- Adhesive Tape Bees/Insects Eggs Environmental
 Food Latex Milk Peanuts
 Seafood Seasonal

Others:

Have you ever been on allergy shots?
 Currently In the past Yes No

Immunizations up to date? Yes No

Reaction to Anesthesia? Yes No

If Yes, Describe
 General Local

Reaction to X-Ray Dye? Yes No

If Yes, describe

Angioneurotic Edema Yes No

Arthritis Yes No

Contact Dermatitis Yes No

Fibromyalgia Yes No

Hay Fever Yes No

Eczema/Psoriasis Yes No

Juvenile Rheumatoid Arthritis Yes No

Immunosuppression Yes No

Lupus/SLE Yes No

Rheumatoid Arthritis Yes No

Bone and Joint Health NONE, IF CHECKED SKIP TO NEXT SECTION

ACL Repair Yes No

Arthroscopy Yes No
If Yes, type?

Cervical Disc Disease/Herniated Disc/Neck Pain Yes No

Degenerative Joint Disease Yes No

Fibromyalgia Yes No

Hip Replacement Yes No

Knee Replacement Yes No

Laminectomy Yes No

Low Back Surgery Yes No

If Yes: Location/Type

Lumbar Disease/Herniated Disc/Low Back Pain Yes No

Neck Disc Surgery Yes No

If Yes: Location/Type

Osteoarthritis Yes No

Osteoporosis Yes No

Other Fracture Repairs Yes No

Please list:

Other Orthopaedic Surgery Yes No

Please list

Scoliosis Yes No

Patient Name

Date of Birth

Cardiovascular NONE, IF CHECKED SKIP TO NEXT SECTION

Angina Yes No

Angioplasty Yes No

Angioplasty with Stent Yes No

Aortic Aneurysm Yes No

Atrial Fibrillation Yes No

Blood Clot/DVT Deep Vein Thrombosis Yes No

Cardiac Arrhythmia Yes No

Cardiac Valve Replacement Yes No

Cardiac Bypass/CABG Yes No

Congestive Heart Failure Yes No

Coronary Artery Disease Yes No

Heart Murmur Yes No

Heart Valve Disease Yes No

High Blood Pressure/Hypertension Yes No

High Cholesterol Yes No

Mitral Valve Prolapse Yes No

If Yes, do you require antibiotic prophylaxis for procedures? Yes No

Myocardial Infarction/Heart Attack Yes No

Pacemaker Yes No

Vascular Disease Yes No

Vasovagal Syncope Yes No

Ear, Nose & Throat

Adenoidectomy Yes No

Chronic Ear Infections Yes No

Chronic Sinus Infections Yes No

Ear Tubes Yes No

Facial Fracture Repair Yes No

Frenulectomy Yes No

Frequent Upper Respiratory Infections Yes No

Hearing Loss Yes No

Lymph Node Biopsy Yes No

Middle Ear Surgery Yes No

Other Ear Surgery Yes No

List

Nasal Polyps Yes No

Nasal Fracture Repair Yes No

Parathyroidectomy Yes No

Parotidectomy Yes No

Perforated Ear Drum Yes No

Peritonsillar Abscess Yes No

Pillar Implant Yes No

Septoplasty Yes No

Sinus Surgery Yes No

TMJ/Temporomandibular Joint Disease Yes No

Tonsillitis Yes No

Tonsillectomy Yes No

Turbinate Reduction Yes No

UPPP Yes No

Vocal Cord Injection Yes No

Eyes NONE, IF CHECKED SKIP TO NEXT SECTION

Cataract Surgery Yes No

Glaucoma Yes No

Lasik Yes No

Past Medical & Surgical History

Patient Name Date of Birth

Gastrointestinal NONE, IF CHECKED SKIP TO NEXT SECTION

- Appendectomy Yes No
- Colon Removal Yes No
- Colostomy Partial Complete Yes No
- Crohn's Disease Yes No
- Eosinophilic Esophagitis Yes No
- Esophagitis Yes No
- Gallbladder Disease Yes No
- Gallbladder Removal/Cholecystectomy Yes No
- GERD Yes No
- Gastric Bypass Yes No
- Heartburn/Reflux Yes No
- Hepatitis Yes No
- Hernia Repair Yes No
- Hiatal Hernia Yes No
- Inflammatory Bowel Syndrome Yes No
- Liver Disease Yes No
- Small Bowel Resection Yes No
- Stomach Ulcer Yes No

Hematology NONE, IF CHECKED SKIP TO NEXT SECTION

- Anemia Yes No
- Bleeding Disorder Yes No
- Hemophilia Yes No
- Sickle Cell Anemia/Disease Yes No
- Sickle Cell Trait Yes No
- Thalassemia Yes No
- Thrombotic Thrombocytopenic purpura (TTP) Yes No

Infectious NONE, IF CHECKED SKIP TO NEXT SECTION.

- AIDS Yes No
- HIV Yes No
- Lyme Disease Yes No
- Methicillin-Resistant Staphylococcus Aureus (MRSA) Yes No
- Tuberculosis Yes No

Kidney/Urinary NONE, IF CHECKED, SKIP TO NEXT SECTION

- Kidney Disease Yes No
If Yes, Describe
- Kidney Failure Yes No
- Kidney Stone Yes No
- Prostate Enlargement/BPH Yes No
- Urinary Tract Infections Yes No

Metabolic/Endocrine

- Diabetes NONE, IF CHECKED SKIP TO NEXT SECTION Yes No
- Gout Yes No
- Hypothyroidism Yes No
- Obesity Yes No
- Thyroid Nodule Yes No

Metabolic/Endocrine (continued)

- Other Thyroid Disease: Yes No
- Thyroidectomy Yes No
If Yes Partial Complete

Neurology None if checked skip to next section

- Autism Yes No
- Alzheimer's Yes No
- Carpel Tunnel Release Yes No
- Migraine Headaches Yes No
- Multiple Sclerosis Yes No
- Parkinson's Disease Yes No
- Seizure Disorder/Epilepsy Yes No
- Stroke/TIA Yes No

Oncology NONE, IF CHECKED SKIP TO NEXT SECTION

- Cancer Yes No
- Head and Neck If Yes, describe
- Breast Ovarian Leukemia Lung Prostrate
- Other
- Have you had radiation therapy? Yes No
- Have you had chemotherapy? Yes No

Psychiatric NONE, IF CHECKED SKIP TO NEXT SECTION

- ADD/ADHD Yes No
- Alcoholism Yes No
- Anxiety Yes No
- Bipolar Disease Yes No
- Depression Yes No
- Drug Abuse Yes No
- Other Mental Illness If Yes, Type Yes No

Respiratory None if checked skip to next section

- Asthma Yes No
- Bronchitis Yes No
- Blood Clot/DVT/Deep Vein Thrombosis Yes No
- COPD/Emphysema Yes No
- Pneumonia Yes No
- Pulmonary Embolism Yes No
- Sarcoidosis Yes No
- Sleep Apnea Yes No

Women's Health NONE, IF CHECKED SKIP TO NEXT SECTION

- Cesarean Section Yes No
- D & C Yes No
- Hysterectomy Yes No
If Yes: Including Ovaries Not Including Ovaries
- Mastectomy Yes No

Past Medical or Surgical History Not Listed Above (Use back of page to continue if needed)

Patient Name	Date of Birth
--------------	---------------

Local Pharmacy

Mail Order Pharmacy

Local Pharmacy Name	Local Pharmacy Phone	Mail Order Pharmacy Name	Mail Order Pharmacy Phone
---------------------	----------------------	--------------------------	---------------------------

Are you currently taking any medications? Yes No

If Yes, Please List Current Medications Below (over the counter and prescription) Use back of page for additional room.

Do you have any medication allergies? Yes No

If Yes, Please List all Known Allergies below:

Habits

Alcohol

Do you drink Alcohol? Yes No If Yes: Beer Wine Spirits

Frequency of Alcohol Use

Social Rare Daily
 Never Recovering Alcoholic

Smoking

An accurate smoking history helps us to assess your risk for certain disorders. Please answer all applicable questions .

Do you smoke? Yes No If Yes, what do you smoke? Cigarettes Cigars Chew Pipe

How much do you smoke per day? For cigarette smokers answer in average number of pack(s) per day

How many years have you smoked?

Have you ever smoked? Yes No If Yes, what did you smoke? Cigarettes Cigars Chew Pipe

How much did you smoke per day? For cigarette smokers answer in average number of pack(s) per day

How many years did you smoke?

Caffeine

Do you drink caffeine on a daily basis? Yes No If Yes, List type and amount.

Coffee Soda

Amt Per Day

Water

Do you drink water on a daily basis? Yes No

Amt Per Day

Recreational Drugs

Do you use recreational drugs? Yes No

If Yes, please list

Home Environment

Is there secondhand smoke exposure at home? Yes No

Are there animals in the home? Yes No Dog Cat Bird

Type of Home Heating: Gas Hot Air Electric Wood Oil Propane Solar

Air Conditioning at Home? Yes No Central Air Room

Other Pets

Other Heat

Patient Signature: _____ **Date:** _____