

Albany ENT & Allergy Services

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

518 701 2000

Adult Patient Health Care Survey

Patients Age 13 and Above

Patient Name			Date of Birth	Social Security #	Gender <input type="radio"/> Male <input type="radio"/> Female Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced
Street Address			City, State and Zip		
Home Phone	Work Phone	Cell Phone	Preferred Contact Number <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell		Email Address
Name of Emergency Contact		Relationship	Phone Number	Employer	Employer Phone

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	

Health Insurance Information **Are you covered by Insurance?** Yes No

If Yes, 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

How did you hear about our office:

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

If Yes please describe the injury and how it happened below:

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

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

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 any unpaid balance. 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).

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

Past Medical & Surgical History

Patient Name

Date of Birth

Allergy/Immunology

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

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

Cardiovascular

- 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

- Cataract Surgery Yes No
- Glaucoma Yes No
- Lasik Yes No

Past Medical & Surgical History

Patient Name Date of Birth

Gastrointestinal

- 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

- 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

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

Kidney/Urinary

- 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 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**
- 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

Oncology

- Cancer Yes No
- Head and Neck Yes, describe
- Breast Ovarian Leukemia Lung Prostate
- Other

Have you had radiation therapy? Yes No

Have you had chemotherapy? Yes No

Psychiatric

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

Respiratory

- 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

- 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
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Local Pharmacy

Mail Order Pharmacy

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

Type

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

Other Pets

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

Other Heat

Air Conditioning at Home? Yes No Central Air Room

Patient Signature: _____

Date: _____