ADULT NEW PATIENT HISTORY FORM

To our new patients: To help us establish each patient with our practice, please provide us your complete health history including all physical and mental symptoms.

PERSONAL HISTORY **Date -**_____

Name: _____ DOB:_____

Current Home (circle one): O'ahu 'Big Island' Maui Kaua'i Moloka'i Other:_____

Occupation _____ Birthplace_____

Primary Care Doctor:_____ Referred by (if different):_____

Preferred Pharmacy for us to call in medications (if necessary): _____

REASON FOR YOUR VISIT: _____

ALLERGIES: (Medicines, Foods, Pollens, Pets etc.) ☐ **No Known Medication Allergies**

_____

_____

CURRENT MEDICATIONS & INHALERS: ☐ **I have a list with me**

	Dose	**Times / Day**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ **Check here if you do not take any medications**

PERSONAL MEDICAL HISTORY

Check those that apply:

☐ High Blood Pressure	☐ Asthma	☐ Acid Reflux
☐ High Cholesterol	☐ Bronchitis/Emphysema	☐ Stomach Ulcer
☐ Heart Disease	☐ Anemia	☐ Irritable Bowels
☐ Stroke	☐ Kidney Disease	☐ Eye Problems/Glaucoma
☐ Diabetes	☐ Jaundice/Liver Disease	☐ Easy Bleeding or Brusing
☐ Thyroid Problem	☐ Migraines	☐ Cancer _____
☐ Other:_____		

PAST MEDICAL, SURGICAL & TRAUMA HISTORY

List prior Surgeries, Injuries, & Hospitalizations **Date/Month and Year**

_____

_____

_____

_____

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes?	☐ YES ☐ NO	If yes, how many? #_____yrs. _____ packs per day
Did you ever smoke?	☐ YES ☐ NO	If yes, when did you quit? _____
Do you drink alcohol?	☐ YES ☐ NO	If yes, how much? Type_____ & _____ drinks per week
Do you drink caffeinated beverages?	☐ YES ☐ NO	If yes, which? _____
Do you use recreational drugs?	☐ YES ☐ NO	If yes, which? _____

-- CONTINUED ON THE OPPOSITE SIDE --

DO ANY OF THESE CONDITIONS RUN IN YOUR FAMILY?:

Bleeding Disorders?	☐ YES	☐ NO	If yes, explain: _____
Problems with Anesthesia?	☐ YES	☐ NO	If yes, explain: _____
Sudden Death in Childhood?	☐ YES	☐ NO	If yes, explain: _____
Cancer?	☐ YES	☐ NO	If yes, explain: _____

REVIEW OF SYSTEMS

Check **YES** for any symptoms that apply to you today:

General

Decreased Activity	Yes ☐
Decreased Appetite	Yes ☐
Fever	Yes ☐
Chills	Yes ☐

Skin

Acne	Yes ☐
Rash	Yes ☐
Scaling	Yes ☐
Itching	Yes ☐
Bruising	Yes ☐
Hair Changes	Yes ☐
Nail Changes	Yes ☐

Eyes

Dry Eyes	Yes ☐
Blurry Vision	Yes ☐
Double Vision	Yes ☐
Excess Tearing	Yes ☐

Ear/Nose/Throat

Tinnitus/Ringing	Yes ☐
Dizziness	Yes ☐
Hoarseness	Yes ☐
Sinus Trouble	Yes ☐
Nose Bleeds	Yes ☐

Respiration

Cough	Yes ☐
Short of Breath	Yes ☐
Wheezing	Yes ☐

Heart and Vascular

Palpitations	Yes ☐
Chest Pain	Yes ☐
Varicose Veins	Yes ☐
Difficulty Lying Down	Yes ☐

Gastrointestinal

Heartburn or Reflux	Yes ☐
Irritable Bowel	Yes ☐
Nausea	Yes ☐
Vomiting	Yes ☐
Diarrhea	Yes ☐
Constipation	Yes ☐

Genitourinary

Incontinence	Yes ☐
Urinary Infection	Yes ☐
Painful Urination	Yes ☐
Frequency	Yes ☐
Hesitancy	Yes ☐

Endocrine

Cold Intolerance	Yes ☐
Heat Intolerance	Yes ☐
Excessive Sweating	Yes ☐

Musculoskeletal

Joint Pain	Yes ☐
Back Pain	Yes ☐
Weakness	Yes ☐
Arthritis	Yes ☐
Cramping	Yes ☐

Neurologic

Headaches	Yes ☐
Seizures	Yes ☐
Tremor	Yes ☐
Numbness	Yes ☐
Tingling	Yes ☐

Psychiatric

Mental Illness	Yes ☐
Anxiety	Yes ☐
Depression	Yes ☐

Hematalogic/Lymphatic

Swollen Nodes	Yes ☐
Bleeding Disorder	Yes ☐
Night Sweats	Yes ☐

Additional Symptoms --

_____

_____

_____

_____

_____/_____/_____

SIGNED: Patient/ Legal Representative **DATE**

ADULT OTOLARYNGOLOGY

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PLEASE PRINT

Patient Name: _____
(Last Name) (First Name) (MI)

Birth date: _____ SSN: _____ (Tricare patients only)

Email address: _____ (optional)

Single:____ Married:____ Divorced:____ Widowed:____ Separated:____ (Please check one)

Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____
□ please check box if same as above

Home Phone: (____) _____ Work Phone (____) _____ Ext: _____ Cell Phone: (____) _____

Ethnicity: _____ Race: _____ Religion: _____ Language: _____
(ex: Chinese, White, Filipino, Hawaiian,) (ex: White, Asian, African American)

Employer:_____ Occupation: _____

Employer address: _____
(Street, City, State, Zip Code)

Referred by: _____ Primary Care Physician: _____

Spouse/Significant other: _____ Birth date: _____ SSN: _____
(Tricare only)

Address: _____ Contact Phone: (____) _____
(Street, City, State, Zip code) □ please check box if same as above

Employer_____ Employer Address: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Contact Phone: (____) _____
(Street, City, State, Zip code) □ please check box if same as above

Insurance Authorization- Please Read and Sign

I hereby authorize Dr. O'Donnell/Dr. Tan to furnish information to insurance carriers or government agencies concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. A copy of this signature is as valid as the original.

Note: All patients are expected to pay their portion of the bill within 30 days upon receipt of first statement. Cash, Check, money orders are all acceptable. If any problems are anticipated in paying the bill on time, please discuss the problem now.

Signature: _____ Date: _____

Print Name: _____