Michael Pickford, MD
Otolaryngologist

GWINNETT ENT

Gwinnett Medical Group

David Braatz
Audiologist

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ AGE: _____

SS #: _____ ( ) MALE ( ) FEMALE MARITAL STATUS: ☐Single ☐Married ☐Divorced ☐Widow

Gender Identity Female_____ Male_____ Other____
Sexual Orientation Straight or heterosexual_____ Bisexual_____ Chose not to disclose_____ Don't know_____ Lesbian, Gay or Homosexual_____ Something else, please describe_____

Preferred Pronoun: She ___ Her___ Hers___ Decline to answer_____ He___ Him___ His___ Other___ Ze___ Hir___
Current Gender: Female___ Male___ Undifferentiated____

ADDRESS: _____ CITY: _____ STATE:_____ ZIP:_____

HOME #: _____ CELL #: _____ WORK #: _____

RACE: _____ ☐Decline to Specify LANGUAGE: _____ ETHNICITY: _____ ☐Decline to Specify

EMAIL ADDRESS: _____ EMPLOYER/SCHOOL: _____

AUTHORIZATION TO RELEASE TEST RESULTS/ CONFIDENTIAL INFORMATION

MAY WE LEAVE CONFIDENTIAL MESSAGES/TESTS RESULTS ON YOUR: ☐HOME # ☐WORK / DAY # ☐CELL #

REPOSNSIBLE PARTY (if different from above)

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE:_____ ZIP:_____

HOME #: _____ CELL #: _____ WORK #: _____

SS #: _____ ( ) MALE ( ) FEMALE MARITAL STATUS: ☐Single ☐Married ☐Divorced ☐Widow

PERSON TO NOTIFY IN CASE OF EMERGENCY

PRIMARY EMERGENCY CONTACT: _____ PHONE: _____

SECONDARY EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY:			POLICY # :
NAME OF INSURED:	SSN#:	BIRTHDATE:	GROUP# :
RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT ☐OTHER			EFFECTIVE DATE:
SECONDARY INSURANCE INFORMATION			
SECONDARY INSURANCE:			POLICY#:

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NAME OF INSURED:	SSN#:	BIRTHDATE:	GROUP#:
RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT ☐OTHER			EFFECTIVE DATE:

PATIENT SIGNATURE: _____ DATE: _____

Pharmacy_____ **Primary Care Doctor**_____

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Patient Name: _____ DOB: _____

Height: _____ Weight: _____

Reason for visit:

_____

How long have you had your symptoms:

_____

What makes is better/worse?

_____

Rate the severity of today's symptoms on a 1-10 scale (10=worst):

_____

Any chance you could be pregnant?

_____

Do you have a history of any of the following medical conditions (please check yes or no):

	Yes	No		Yes	No
High Blood Pressure			Fever		
Diabetes			Chills		
Thyroid Disease			Weight Loss		
Stroke			Night Sweats		
Liver Disease			Loss of appetite		
Bleeding Disorder			Bronchitis		
Heart Disorder			Shortness of Breath		
Depression			Cough		
Asthma/COPD			Heartburn		
Seizure			Jaundice		
Stomach Problems			Nausea		
Cancer			Diarrhea		
Kidney Disease			Constipation		
Skin Disorders			Dizziness		
Numbness			Weakness		

	Yes	No		Yes	No		Yes	No
Headache			Nasal Obstruction			Difficulty swallowing		
Failing Vision			Nosebleed			Unable to clear throat		
Eye Pain			Loss of smell/taste			HIV/AIDS		
Double Vision			Hearing Loss			Hoarseness		
Nasal Congestion			Ringing in ears			Pregnant		
Facial Pain			Ear Pain			Neck Mass/swollen glands		
Nasal Discharge			Ear Drainage			Snoring		
Post-Nasal Drip			Off Balance			Sometimes unable to sleep		
Frequent Sneezing			Ear Fullness/Pressure			Fatigue		

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Patient Name: _____ DOB: _____

Social History:
Have you ever smoked? If so, how many years? Age started? How many packs per day? When did you quit?
_____
_____
Do you consume alcoholic beverages? If so, how many drinks per day? What is it that you may drink?
_____
_____
Have you ever used recreational drugs? If so, what type?
_____
_____
Do you consume caffeine products? If so, how many per day? What is it that you drink?
_____
_____

Medication History:
Are you allergic to any medications? If so, please list them with the type of reaction.
_____
_____
Please list your current medications, including Over The Counter, with dosage or attach a list to this document.
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Have you had a pneumonia vaccination/ FLU vaccination? Yes_____ No_____ Date: _____

Family History:
Please note the illnesses that are present in your immediate relatives (parents, children, siblings).
(Cause/Condition: heart attack or heart disease, cancer, allergies, stroke hearing loss, high blood pressure, bleeding problems, Sickle Cell/Trait, asthma, thyroid disease, diabetes, and or any other major or pertinent medical conditions.

Relationship	Family Member Name	Deceased Y or N	Age of Death	Cause/Condition

PATIENT SIGNATURE: _____ DATE: _____

Time: _____

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Past Surgeries

Procedure:	Date:	Procdure:	Date: