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

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

PATIENT SIGNATURE: ______________________ DATE: __________ Time: ________

Pharmacy Name: ______________________ Phone #: ______________________

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Patient Name: ______________________________ **DOB:** ______________

PCP: ______________________________ 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
Severe Headache			Nasal Obstruction			Difficulty Swallowing		
Failing Vision			Nosebleed			Can't Clear Throat		
Eye Pain			Loss of smell/taste			Cough		
Double Vision			Hearing Loss			Hoarseness		
Nasal Congestion			Ringing in ears			Heartburn		
Facial Pain			Ear Pain			Neck Mass/swollen glands		
Nasal Discharge			Ear Drainage			Snoring		
Post-Nasal Drip			Dizzy/off Balance			Stop breaking during Sleep		
Frequent Sneezing			Ear Fullness/Pressure			Sleepy in the daytime		

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Patient Name: ______________________________________ **DOB:** ________________

Social History:
Have you ever smoked? If so, how many years? How many packs per day? When did you quit?

____

____

Do you consume alcoholic beverages? If so, how many drinks per day?

____

____

Do you consume caffeine products? If so, how many per day?

____

____

Medication History:
Are you allergic to any medications? If so, please list them with the type of reaction.

____

____

Please list your current medications 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

Past Surgeries:

Procedure:	Date:	Procedure:	Date
____________________	_____________	__________________	_________________
____________________	_____________	__________________	_________________

Please use the other side of this form if you have more surgeries to list.