MIDWEST
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9 Convenient Locations:
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www.ENTandSLEEP.com
Office: 618-628-0715
Fax: 888-371-4468

Patient Information

Name (First, M.I., Last): _____ Nickname: _____

D.O.B.: _____ Gender: Male/Female Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Best Time to Call: _____

Referring Physician: _____ Primary Physician: _____

(If different than mailing…)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber Information

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Address (*if different from above):* _____

Emergency Contact

Name: _____

Relationship to Patient: _____ Phone Number: _____

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Health and History Form

Medications: *(Please list all current prescription/non-prescription medications)*

Medication Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

*If you need more room, please list additional medications on the back of the last page.

Pharmacy Name: _____ Location: _____

Allergies: *(List any medications that have previously caused an allergic reaction)*

_____

_____

Major Illnesses, Surgeries, Treatments or Conditions:

_____

_____

Social History

☐	Yes	☐	No	Do you smoke?
☐	Yes	☐	No	Are you around other smokers?
☐	Yes	☐	No	Do you/have you used illegal drugs?
☐	Yes	☐	No	Do you consume alcohol?
☐	Yes	☐	No	Do you drink coffee, soft drinks, or other caffeine drinks?
☐	Yes	☐	No	Do you exercise on a routine basis?
☐	Yes	☐	No	Do you have a stressful lifestyle?
☐	Yes	☐	No	Do you live an isolated lifestyle?
☐	Yes	☐	No	Do you work more than sixty hours a week?

Employer: _____ Occupation: _____

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Personal Medical Conditions

Please check all that apply:

____ Alcoholism	____ Diabetes	____ High Blood Pressure	____ Pertussis
____ Allergies	____ Ear Infections	____ High Cholesterol	____ Psych. Disorder
____ ALZHEIMER'S DISEASE	____ Emphysema	____ Iron Disease	____ Reflux
____ Anemia	____ Epilepsy	____ Kidney Disease	____ Rubella
____ Anesthesia Comp.	____ Feq. Cold/Pharyngitis	____ Leg Cramps	____ Seizures
____ Aneurysm	____ Glaucoma	____ Measles	____ Stroke
____ Arthritis	____ Gout	____ Mental Illness	____ Thyroid Disease
____ Asthma	____ Headaches	____ Migraine	____ Tonsillitis
____ Breast Cancer	____ Hearing Loss	____ Muscle Disease	____ Tuberculosis
____ Colon Cancer	____ Heart Attack	____ Osteoporosis	____ Ulcers
____ Colon Polyps	____ Heart Disease	____ Other Cancer	____ Vertigo

Family Medical Conditions

Please check all that apply:

____ Alcoholism	____ Diabetes	____ High Blood Pressure	____ Pertussis
____ Allergies	____ Ear Infections	____ High Cholesterol	____ Psych. Disorder
____ ALZHEIMER'S DISEASE	____ Emphysema	____ Iron Disease	____ Reflux
____ Anemia	____ Epilepsy	____ Kidney Disease	____ Rubella
____ Anesthesia Comp.	____ Feq. Cold/Pharyngitis	____ Leg Cramps	____ Seizures
____ Aneurysm	____ Glaucoma	____ Measles	____ Stroke
____ Arthritis	____ Gout	____ Mental Illness	____ Thyroid Disease
____ Asthma	____ Headaches	____ Migraine	____ Tonsillitis
____ Breast Cancer	____ Hearing Loss	____ Muscle Disease	____ Tuberculosis
____ Colon Cancer	____ Heart Attack	____ Osteoporosis	____ Ulcers
____ Colon Polyps	____ Heart Disease	____ Other Cancer	____ Vertigo

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History of the Present Illness

What is the reason for your visit today?

_____

_____

What are the characteristics or description of the problem? *(i.e. stabbing pain, dull ache, anxiety)*

_____

_____

How long has the problem been present?

_____

Where is the problem located? *(i.e. right ear, nose, throat)*

_____

How bad is the problem? *(On a scale from 1-10, with 10 being the worst)*

_____

How often does it bother you?

_____

What events surround or impact the problem? *(i.e. shortness of breath when climbing stairs, after surgery, certain time of day)*

_____

_____

What treatments/actions have had an effect, positive or negative, on the problem? *(i.e. Tylenol did not relieve pain, antacid provided short term relief, nasal sprays, antibiotics, steroids)*

_____

_____

Are there any other symptoms that appear to be related to the problem?

_____