Northwell Health Physician Partners
Otolaryngology at Huntington
205 East Main Street, Suite 2-4
Huntington, NY 11743

What are your concerns for today's visit? ___________________________________ Date: ____________________

LIST ANY **ALLERGIES TO MEDICATIONS:**
____
____
____

PAST MEDICAL HISTORY:
Do you have any of the following illnesses; for "YES" answers, please explain

	Yes	No	Explain		Yes	No	Explain
Diabetes	☐	☐	________________	Stomach or Intestinal Problems	☐	☐	________________
Hypertension (high blood pressure	☐	☐	________________	Allergy problems/ therapy	☐	☐	________________
Thyroid Problem	☐	☐	________________	Kidney Problems	☐	☐	________________
Heart Disease/Cholesterol	☐	☐	________________	Neurological Problems	☐	☐	________________
Respiratory Problems	☐	☐	________________	Hepatitis	☐	☐	________________
Other Medical Diagnosis	☐	☐	________________	Immune Deficiency	☐	☐	________________
Facial Fracture/Trauma	☐	☐	________________		☐	☐	________________

2) Please list any operations (and dates) you have ever had (including tonsils and adenoids):

Type of surgery	Date of surgery	Hospital or place of surgery

3) Please List any current medications (and amounts, times per day):
(including aspirin, antacids, vitamins, hormone replacements, birth control, herbal supplements, OTC nasal sprays/ cold/sinus/allergy meds)

____
____
____

SOCIAL HISTORY

	Yes	No		
Do you smoke?	☐	☐	How Much?	How many years? ________________
If no, did you smoke previously?	☐	☐	Are you exposed to second hand smoke?	☐ Yes ☐ No
Do you drink alcohol?	☐	☐	How much? ________________________	What type(s)? ____________________
Use of recreational drugs?	☐	☐	How often? ________________________	What type(s)? ____________________

FAMILY HISTORY
Please check the "YES" or "NO" box to indicate whether any relatives have any of the following illnesses:
If "YES", please indicate which relative(s) have the illness.

	Yes	No	
Hearing or balance problems	☐	☐	____________________
Allergy	☐	☐	____________________
Diabetes	☐	☐	____________________
Cancer	☐	☐	____________________
Bleeding Disorder	☐	☐	____________________
Anesthesia problems	☐	☐	____________________
Heart Problems	☐	☐	____________________
Other	☐	☐	____________________

Reviewed by:

Northwell Health Physician Partners
Otolaryngology at Huntington
205 East Main Street, Suite 2-4
Huntington, NY 11743

Please provide the following medical information to the best of your ability:
Review of Systems:

1. Please check the “YES” or “NO” box to indicate whether you presently have any of the following symptoms.
2. For any “YES” response, please check the “current” box if this symptom relates to the reason for your visit today..

		Yes	No	Current		Yes	No	Current
ALLERGY	Sneezing	☐	☐	☐	Post nasal drip	☐	☐	☐
	Seasonal allergy	☐	☐	☐		☐	☐	☐
ENT	Ear Pain or itch	☐	☐	☐	Ear drainage	☐	☐	☐
	Hearing Loss	☐	☐	☐	Ear noises	☐	☐	☐
	Recurrent ear-infections	☐	☐	☐	Swelling neck/ face	☐	☐	☐
	Dizziness, Vertigo	☐	☐	☐	Lightheadedness	☐	☐	☐
	Nasal Congestion	☐	☐	☐	Sinus pressure/ pain	☐	☐	☐
	Nose bleeds	☐	☐	☐	Sense of smell problem	☐	☐	☐
	Recurrent sinus infections	☐	☐	☐	Discolored nasal discharge	☐	☐	☐
	Problem snoring	☐	☐	☐	Snoring with pauses	☐	☐	☐
	Hoarseness	☐	☐	☐	Throat pain	☐	☐	☐
	Throat clearing	☐	☐	☐	Throat dryness/ itching	☐	☐	☐
RESPIRATORY	Cough	☐	☐	☐	Coughing blood	☐	☐	☐
	Wheezing	☐	☐	☐	Shortness of breath	☐	☐	☐
	Noisy breathing	☐	☐	☐		☐	☐	☐
EYES	Eye pain	☐	☐	☐	Watery or itchy eyes	☐	☐	☐
GI	Difficulty swallowing	☐	☐	☐	Heartburn, reflux	☐	☐	☐
NEURO	Headache	☐	☐	☐	Passing out	☐	☐	☐
GENERAL	Chills	☐	☐	☐	Weight loss/ pain	☐	☐	☐
	Fatigue	☐	☐	☐	Daytime sleepiness	☐	☐	☐
ENDO	Feel warmer than others	☐	☐	☐	Feel cooler that others	☐	☐	☐
HEME/LYM	Swollen glands	☐	☐	☐	Sweating at night	☐	☐	☐
	Bleeding problems	☐	☐	☐	Easy bruising	☐	☐	☐
CARDIAC	Chest pain	☐	☐	☐	Palpitations	☐	☐	☐
MSK	Joint aches	☐	☐	☐	Muscle aches	☐	☐	☐
SKIN	Rash	☐	☐	☐	Hives	☐	☐	☐
	Itching	☐	☐	☐	Skin/hair changes	☐	☐	☐
	Strawberry birth marks	☐	☐	☐		☐	☐	☐
PSYCH	Depression	☐	☐	☐	Anxiety or panic	☐	☐	☐

Reviewed by:

Northwell Health Physician Partners
Otolaryngology at Huntington
205 East Main Street, Suite 2-4
Huntington, NY 11743

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

THE FOLLOWING SERIES OF QUESTIONS ARE ASKED IN ACCORDANCE WITH FEDERAL AND STATE LEGISLATION. THE PATIENT INFORMATION BOOKLET CONCERNS THE FOLLOWING TOPICS.

1. NOTICE OF PRIVACY

Please list anyone who is authorized to have access to your healthcare information and/or speak with our office on your behalf:

____

____

2. PERMISSIBLE COMMUNICATION:

- **APPOINTMENT REMINDERS**
  I understand that Northwell Physician Partners Otolaryngology at Huntington utilizes Call Reminders for appointment scheduled with this practice via the following communication method:

  APPOINTMENT REMINDERS: YES______ NO______
  *(if **Yes**, please check one option)*

HOME PHONE: ___________________ CELL PHONE: _____________________ TEXT: ________________

- **OTHER CLINICAL COMMUNICATIONS FROM THE PRACTICE:**
  I understand that Northwell Physician Partners Otolaryngology at Huntington and I may exchange information per my request via the following communication method:

  CLINICAL COMMUNICATION: YES______ NO______ *(if **Yes**, please check one option)*

  HOME PHONE: ________________________ CELL PHONE______________________

X____ _________________________
Patient / Guardian / Representative Consent ***Date***

3. In compliance with new government regulations, we are required to collect certain demographic information from all of our patients. Through the collection of this data, there will be an attempt to improve your quality of care.

Race:

- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian
- ☐ White
- ☐ Declined

Ethnicity:

- ☐ Hispanic Origin
- ☐ Non- Hispanic Origin
- ☐ Declined

Preferred Language: ____________________

4. MEDICATION RECONCILIATION ePRESCRIBE

PHARMACY NAME: ______________________

I understand that Northwell Physician Partners Otolaryngology at Huntington may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

X____ _________________________
Patient / Guardian / Representative Consent ***Date***

5. PATIENT PORTAL

I agree that the email address I have provided may be used to generate a patient portal account with Northwell Physician Partners Otolaryngology at Huntington. The patient portal gives access to a clinical summary from your last visit.

X____ _________________________
Patient / Guardian / Representative Consent ***Date***