DATE:_____

PATIENT'S NAME:_____ DOB:_____

REASON FOR TODAY'S VISIT:

_____
_____
_____
_____

WHEN DID THE SYMPTOMS START? _____

THE SYMPTOM INTENSITY IS: Mild Moderate Severe

THE SYMPTOMS ARE: Intermittent Constant

WHAT MAKES THE SYMPTOMS WORSE? _____

WHAT MAKES THE SYMPTOMS BETTER? _____

CURRENT MEDICATIONS AND DOSAGES. PLEASE INCLUDE SUPPLEMENTS AND NASAL SPRAYS.

_____
_____
_____
_____
_____

HAVE YOU HAD ANY REACTIONS TO MEDICATIONS: Yes No

PLEASE TELL US THE MEDICATIONS AND WHAT REACTION YOU HAD (RASH, SWOLLEN TONGUE, STOPPED BREATHING, VOMITING, ABDOMINAL PAIN, DIARRHEA)

_____
_____
_____
_____

PLEASE LIST ALL PREVIOUS MEDICAL CONDITIONS, PREVIOUS SURGERIES AND DATES, AND HOSPITALIZATIONS AND DATES

_____
_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

THYROID PROBLEMS **No** **Father** **Mother** **Brother** **Sister**

HEARING LOSS **No** **Father** **Mother** **Brother** **Sister**

HEART DISEASE **No** **Father** **Mother** **Brother** **Sister**

SOCIAL HISTORY

DO YOU DRINK ALCOHOL? **Yes** **Never** **Quit (year quit _____)**

WHAT ALCOHOL CONTAINING BEVERAGE DO YOU DRINK? BEER WINE

OTHER _____

HOW OFTEN DO YOU DRINK ALCOHOL? OCCASIONALLLY WEEKENDS DAILY

DO YOU SMOKE? **Yes** **Never** **Quit (year quit _____)**

CIGARETTES CIGARS MARIJUANA CHEWING TOBACCO SNUFF PAN

OTHER _____

HOW MUCH DO YOU SMOKE? _____ PACK(S) PER DAY,

HOW MANY YEARS DID YOU SMOKE OR HAVE YOU BEEN SMOKING? _____ YEARS

DO YOU USE ANY RECREATION DRUGS? **Yes** **Never** **Quit (year quit _____)**

IF YES OR QUIT, PLEASE LIST DRUGS USED: _____

OCCUPATION: _____

IF RETIRED, WHAT WAS THE LAST THING YOU DID BEFORE YOU RETIRED? _____

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED ENGAGED

ARE YOU (THE PATIENT) EXPOSED TO SECOND HAND SMOKE? **YES** **NO**

DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS?

CONSTITUTIONAL SYMPTOMS

Fevers	Yes	No
Night Sweats	Yes	No
Weight Loss	Yes	No

EYES

Pain	Yes	No
Blurred Vision	Yes	No
Double Vision	Yes	No
Loss of Vision	Yes	No

CARDIOVASCULAR

Chest Pain	Yes	No
Heart Failure	Yes	No

RESPIRATORY

Difficulty Breathing	Yes	No
COPD/emphysema	Yes	No
Asthma	Yes	No

GASTROINTESTINAL

Heartburn	Yes	No
Difficulty Swallowing	Yes	No

INTEGUMENTARY

Rash	Yes	No

PSYCHIATRIC

Depression	Yes	No
Impaired Memory	Yes	No

EAR NOSE THROAT MOUTH

Hearing Loss	Yes	No
Ringing in Ears	Yes	No
Ear Pain	Yes	No
Ear Discharge	Yes	No
Dizziness	Yes	No
Ear infections	Yes	No
Surgery in the Ears	Yes	No
Sore Throat	Yes	No
Had Tonsils Out	Yes	No
Hoarseness	Yes	No
Mouth Lesions	Yes	No
Snoring	Yes	No
Stop Breathing at Night	Yes	No
Tired During Day	Yes	No

ENDOCRINE

Thyroid Disease	Yes	No
Diabetes	Yes	No

ALLERGIC/IMMUNOLOGIC

Sneezing	Yes	No
Runny Nose	Yes	No
Nasal Congestion	Yes	No
Facial Pain	Yes	No
Nosebleed	Yes	No
Lost Sense of Smell	Yes	No

GENITOURINARY

Frequent Urination	Yes	No
Stones	Yes	No

MUSCULOSKELETAL

Joint Pain	Yes	No
Back Pain	Yes	No

HEMATOLOGIC/LYMPHATIC

Bleed Easily	Yes	No
Enlarged Glands	Yes	No

NEUROLOGIC

Headaches	Yes	No

MOUTH

Dentures	Yes	No

*If you wear dentures please be prepared to remove them for exam.

Sino Nasal Diagnosis

Date: _____

Patient name: _____ DOB: _____

Sometimes it can be difficult to determine if your sinus symptoms are the result of allergies and the common cold or if pressure, pain and dizziness are being caused by chronic sinusitis. To help you determine which sinus treatment is the right option for you, take a moment to complete this assessment.

No symptoms "0" Severe Symptoms "5"

1. Need to blow nose	0	1	2	3	4	5	
2. Sneezing	0	1	2	3	4	5	
3. Runny nose	0	1	2	3	4	5	
4. Cough	0	1	2	3	4	5	
5. Post-nasal discharge	0	1	2	3	4	5	
6. Thick nasal discharge	0	1	2	3	4	5	
7. Ear Fullness	0	1	2	3	4	5	
8. Dizziness	0	1	2	3	4	5	
9. Ear pain	0	1	2	3	4	5	
10. Facial pain/pressure	0	1	2	3	4	5	
11. Difficulty falling asleep	0	1	2	3	4	5	
12. Wake up at night	0	1	2	3	4	5	
13. Lack of a good nights sleep	0	1	2	3	4	5	
14. Wake up tired	0	1	2	3	4	5	
15. Fatigue	0	1	2	3	4	5	
16. Reduced productivity	0	1	2	3	4	5	
17. Reduced concentration	0	1	2	3	4	5	
18. Frustrated/restless/irritable	0	1	2	3	4	5	
19. Sad	0	1	2	3	4	5	
20. Embarrassed	0	1	2	3	4	5	

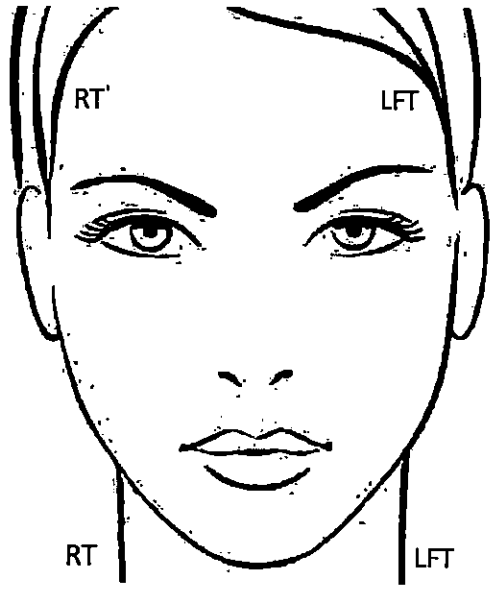
Sinus Medication History:

_____
_____
_____
_____
_____

Doctor's Notes:

_____
_____
_____
_____
_____

If you have **facial pain** or **pressure**, please place an "X" on the face below to show where **you are feeling that pain or pressure:**



Please rate your current facial pain/pressure on a scale of 0 to 5. 0 being no pain, and 5 being extremely painful.

0 1 2 3 4 5

Duration and Frequency

Have you experienced these symptoms for 12 or more consecutive weeks?

Yes No

Have you experienced these symptoms for 10 or more days four or more times (with periods of no symptoms) in the last 12 months?

Yes No

On what date did you first start experiencing these symptoms? _____

NO SHOW POLICY

With MAB ENT, if you do not cancel or reschedule your appointment with at least 24 hours notice or if you are more than 15 minutes late, we may assess a $25.00 "no show" service charge to your account. This no show charge is not reimbursable by your insurance company. You will be directly billed for it. After a no show, our practice may decide to terminate its relationship with you.

I acknowledge the no show policy.

_____ _____

Patient's Signature **Date**

MEDICAL ASSOCIATES OF BREVARD

New Patient Registration

Patient Information

Patient Name

_____

First MI Last

DOB ___/___/_____ SS# _____

Marital Status_____ ○ MALE ○ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

_____

○ Check if same as patient's address

Race

○ American Indian or Alaska Native ○ Asian
○ Native Hawaiian ○ Black or African American ○ White
○ Other Pacific Islander ○ Prefer not to answer

Ethnicity

○ Hispanic/Latino ○ Non-Hispanic/Latino
○ Prefer not to answer

Preferred Language

○ English ○ Spanish ○ French ○ Indian (includes Hindu & Tamil) ○ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

○ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

○ Check if same as patient's address

Employer _____

MEDICAL ASSOCIATES OF BREVARD

New Patient Registration

HIPAA Release

Patient Name

First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No
If you answered yes to either, please provide us a copy.

Emergency Contact:

Name Relationship

Phone #

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

Name Relationship

Phone #

Name Relationship

Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification:
I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.