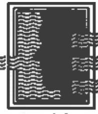


EASTERN VIRGINIA
EAR, NOSE & THROAT
SPECIALISTS
www.easternvaent.com

New Patient ROS

Patient Name: ______________________ Date of Birth: ______________

Today's Date: ______________ Primary Care Physician: ______________________

Height: ______________ Weight: ______________

What is your Ear, Nose, and/or Throat complaint that we are seeing you for today?

____

____

REVIEW OF SYSTEMS

Please CHECK if you are CURRENTLY having any of these symptoms

HEENT
____ Blurred Vision
____ Ear Discharge
____ Ear Infection
____ Ear Pain
____ Eye Redness
____ Frequent Colds
____ Hearing Loss
____ Hoarseness
____ Nasal Congestion
____ Nose Bleeds
____ Oral Ulcers
____ Ringing in the Ears
____ Seasonal Allergies
____ Sinus Pain
____ Sore Throat
____ Visual Disturbances
____ Voice Changes

GENERAL
____ Chills
____ Fever
____ Fatigue

NECK
____ Neck Mass
____ Neck Pain
____ Swollen Glands

RESPIRATORY
____ Cough
____ Difficulty Breathing
____ Snoring

CARDIAC
____ High Blood Pressure
____ Shortness of Breath

GASTROINTESTINAL
____ Difficulty Swallowing
____ Indigestion
____ Nausea
____ Vomiting

MUSCULOSKELETAL
____ Joint Pain
____ Muscle Pain

NEUROLOGICAL
____ Decreased Sense of Smell
____ Dizziness
____ Headache

ENDOCRINE
____ Appetite Changes
____ Cold Intolerance
____ Thyroid Problems

HEMATOLOGICAL
____ Abnormal Bleeding
____ Anemia
____ Easy Bruising

FOR MD USE ONLY

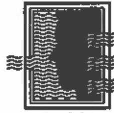
___ Allergy Inhalant Testing
___ Audio/Tymp
Follow Up ENT: ______________

___ Total IgE
___ Labs
Follow Up Allergy: ______________

___ Foods (IgE/IgG)
___ VNG/ABR
Follow Up Audiology: ______________

Consults/Referrals: ______________
Follow Up Audio/ENT: ______________

Radiology: ______________



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MEDICAL HISTORY

Name: ________________________________ Today's Date: ______________________

Date of Birth: ____________________ Family Doctor/PCP: ____________________

Pharmacy Name: __________________________ Pharmacy Phone Number: ______________

Pharmacy Address: ____

Preferred Language: __________________ Occupation: _________________________

Marital Status: ____ Married ____ Single ____ Widowed ____ Divorced

Race: ____ White ____ African American ____ Asian ____ American Indian ____ Pacific Islander

____ Other ____ Decline to Answer

Ethnicity: ____ Hispanic ____ Non-Hispanic ____ Decline to Answer

MEDICAL PROBLEMS

PLEASE CHECK IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS

ENT

- ☐ Allergies
- ☐ Asthma
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Eustachian Tube Dysfunction
- ☐ Hearing Loss
- ☐ Meniere's disease
- ☐ Nasal Polyp
- ☐ Neck Mass
- ☐ Parotid Gland Abnormality
- ☐ Perforated Ear Drum
- ☐ Reflux/GERD
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Thyroid Gland Abnormality
- ☐ Tinnitus
- ☐ Tonsillitis
- ☐ Other: __________

GENERAL MEDICAL

- ☐ Anemia
- ☐ Arthritis
- ☐ Birth Defects
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hypertension (High Blood Pressure)
- ☐ Hepatitis
- ☐ HIV
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Skin Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Urinary Problems
- ☐ Venereal Disease

ALLERGIES TO MEDICATION

PLEASE LIST ALL OF YOUR MEDICATION ALLERGIES AND REACTIONS	☐ NO KNOWN ALLERGIES (CHECK)

Do you have an allergy to Latex? ____ Yes ____ No

Do you have an allergy to Intravenous Dye? ____ Yes ____ No

Do you have any allergies to foods? ____ Yes ____ No Please list: ______________________

FAMILY HISTORY

Allergy ___ Yes ___ No Relative: ____________________

Asthma ___ Yes ___ No Relative: ____________________

Bleeding Disorder ___ Yes ___ No Relative: ____________________

Cancer ___ Yes ___ No Relative: ____________________

Thyroid Disorder ___ Yes ___ No Relative: ____________________

SOCIAL HISTORY

Tobacco Use: ____ Yes ____ No ____ Former

Packs/Day: _____

Tried to Quit: ____ Yes ____ No

Are you exposed to second hand smoke: ____ Yes ____ No

Do you smoke daily: ____ Yes ____ No

How many years have you smoked: ____

Year you Quit: ________

Alcohol Use: ____ Yes ____ No **Frequency:** ____ Daily ____ Weekly ____ Monthly ____ Rarely

Recreational Drug Use: ____ Yes ____ No If yes, what type: ____________________

Pets: ____ Dog ____ Cat ____ Horse ____ Bird Other, please list: ____________________

Are you currently pregnant: ____ Yes ____ No If Yes, how many weeks: ______________

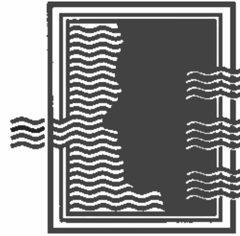
MEDICATIONS

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS	☐ NO MEDICATIONS (CHECK)

SURGICAL HISTORY

PLEASE LIST YOUR SURGICAL HISTORY AND DATE OF SURGERY	☐ NO SURGICAL HISTORY (CHECK)

Jeffrey P. Powell, M.D., D.D.S., F.A.C.S.
Charles H. Dennis, M.D. *Emeritus*
Alan S. Keyes, M.D., F.A.C.S
Kimberly Pasquale, M.D., F.A.C.S.
Richard F. Debo, M.D., F.A.C.S.
Ryan P. Hester, M.D.
David W. Leonard, M.D., F.A.C.S.
Kenneth L. Mayes, M.D. *Emeritus*
Kim Scott, F.N.P., A.E.-C, CORLN
Alexis L. Buettner, MPA, PA-C



EASTERN VIRGINIA
EAR, NOSE & THROAT
SPECIALISTS

Administrator - Melanie Hoy
Audiology - Paula A. Abraham, Au.D., CCC-A
Stephanie R. Howard, M.A., CCC-A
Stephanie M. Collins, Au.D., CCC-A
Michael W. Lemay, Au.D., CCC-A

IMPORTANT INFORMATION

PLEASE READ

Consent to perform in-office procedure/surgery
(Nasal Endoscopy or Laryngoscopy)

The purpose of this form is to make you aware of a certain charge that may apply to your visits if you are complaining of sinus, ear or throat problems.

If you are here for a consultation, follow-up or post op visit, it may be necessary for the doctor, nurse practitioner or physician assistant do a certain procedure (Nasal Endoscopy or a Laryngoscopy) in your evaluation and treatment. According to The American Medical Association the procedures, Nasal Endoscopy and Laryngoscopy, are re-classified as an in-office procedure/surgery. Insurance companies sometimes apply these procedures/surgeries to your coinsurance and/or deductible. Therefore, you may owe more than just your office co-payment for today's services. If you have any questions about your specific insurance plan benefit and your financial responsibility, please ask our financial advisor before seeing the provider. Please indicate your understanding and consent of these procedures by signing below.

- ☐ **I understand and give consent** to a Nasal Endoscopy or Laryngoscopy for my evaluation and/or treatment if the provider finds it medically necessary.

- ☐ **I understand BUT do NOT give consent** to a Nasal Endoscopy or Laryngoscopy. I understand without the procedure it will be very difficult for the provider to give me a proper diagnosis and treatment of my illness.

Patient Name ____________________ Date ____________

Signature of Patient or Guardian ____________________ Relationship to patient ____________

Witness ____________________ Date ____________

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