Otolaryngology Specialists of North Texas
Pediatric and Adult Ear, Nose, & Throat Specialists

Dr. Rohn and Dr. Gamble
6300 W Parker Rd Suite G24
Plano, TX 75093
972-378-0633

7515 Greenville Ave Suite 410
Dallas, TX 75231
214-239-1641

Patient Intake Form- Adult

Date: _____

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Date of Birth ____/____/_____

Age _____ Sex _____ SSN :_____Race _____ Ethnicity ____Hispanic _____Not Hispanic

Address _____ Apt # _____ City _____ State _____ Zip _____

Email Address _____ Preferred Language _____

Home Phone _____ Cell Phone _____ Work Phone _____

How may our office best contact you? (check one) _____Home Phone _____Cell Phone _____Work Phone

Preferred method of appointment reminder? _____Text _____Email _____Phone (circle: cell or home)

Occupation _____ Employer _____

PHARMACY

Pharmacy Name _____ Phone _____ Fax _____

Address _____ City/State/Zip _____

INSURANCE INFORMATION

Primary Insurance Carrier _____

ID# _____ _____

Group # _____

Subscriber Name _____

Subscriber SS # _____

Subscriber Birth Date _____

Relationship to Patient _____

Employer _____

Secondary Insurance Carrier _____

ID# _____

Group # _____

Subscriber Name _____

Subscriber SS# _____

Subscriber Birth Date _____

Relationship to Patient _____

Employer _____

REFERRING PHYSICIAN

Physician Name _____ Practice Phone _____

May we thank someone else (non-physician) for referring you to our office? _____

ALLERGY INFORMATION

Drug Allergies _____Environmental Allergies_____

Are you allergic to latex? _____ Yes _____ No Are you allergic to medical tape? _____ Yes _____ No

SOCIAL HISTORY

Exercise: Yes _____No_____ How often: Daily_____2-3x a week_____3-4x a week_____

Use Alcohol: Never_____1 a month_____2-4 a month_____2-3 a week_____4+ a week ____Number in one occasion_____

How often did you have 6+ drinks on one occasion in the past year: Never_____ Monthly_____ Weekly_____ Daily _____

Do you CURRENTLY smoke or use tobacco products: Yes___ No ___What do you use_____ How often ____Daily ____Occ.

Have you EVER smoked or used tobacco products: Yes_____ No_____ How often did you use: Everyday____ Occasionally_____

How much _____ How many years _____When did you quit _____What did you use _____

Have you used drugs in the last 12 months (Marijuana/Heroin/LSD/Cocaine/Other) Yes_____ No_____

Patient Name: _____ Date of Birth: _____

MEDICATION

Please list all medications you are currently taking including over the counter medications, herbals, etc.

____ No Current Medications

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

HEALTH HISTORY

What problems are you here for today? _____

Do you currently have or frequently experience:

____Alcoholism	____Cancer	____Heart Failure	____Mental Illness
____Anemia	____Depression	____Hepatitis	____Reflux
____Arthritis	____Diabetes	____High Blood Pressure	____Sleep Apnea
____Atrial Fibrillation	____Emphysema	____High Cholesterol	____ Stroke
____Asthma	____Epilepsy/Seizures	____HIV/AIDS	____ Thyroid Problem
____Birth Defects	____Glaucoma	____Kidney Disease	____ Tuberculosis
____Bladder Disease	____Headaches	____Liver Problem	____Weight Loss/Gain
____Bleeding Disorder	____Heart Attack	____Lung Problem	____Other:_____

Have you undergone any of the following surgeries?

Tonsillectomy	Date:_____	Adenoidectomy	Date:_____
Ear Surgery	Date:_____	Thyroid Surgery	Date:_____
Ear Tubes	Date:_____	Nasal/Sinus Surgery	Date:_____

Other_____

_____

FAMILY HISTORY

Has anyone in your family had: M=Mother, F=Father, S=Sibling, MGM= Maternal Grandmother, MGF= Maternal Grandfather, PGM= Paternal Grandmother, or PGF= Paternal Grandfather

____Alcoholism	____Cancer	____Heart Failure	____Mental Illness
____Anemia	____Depression	____Hepatitis	____Reflux
____Arthritis	____Diabetes	____High Blood Pressure	____Sleep Apnea
____Atrial Fibrillation	____Emphysema	____High Cholesterol	____ Stroke
____Asthma	____Epilepsy/Seizures	____HIV/AIDS	____ Thyroid Problem
____Birth Defects	____Glaucoma	____Kidney Disease	____ Tuberculosis
____Bladder Disease	____Headaches	____Liver Problem	____Weight Loss/Gain
____Bleeding Disorder	____Heart Attack	____Lung Problem	____Other:_____

Other:_____

Patient Name:_____Date of Birth: _____

PATIENT REVIEW OF SYSTEMS

Do you consider yourself generally: _____Healthy _____Change in appetite _____ Fever _____
Do you frequently have or frequently experience: (Please check ALL that apply)

Allergy/Immunologic	**____None**	____Reactions	____Sneezing	____Eye Irritation
		____Other:_____		
Eyes	**____None**	____Irritation from light	____ Blurred Vision	____Other_____
Ears, Nose, Throat & Mouth	**____None**	____Itching Nose	____Rhinitis	____ Bruxism (teeth grind)
		____ Nose Blocked	**____**Sores in Mouth	____Post Nasal Drip
		____Teeth Hurt	____Painful Swallowing	____Pressure in Ear
		____Hearing Loss	____Difficulty Swallowing	
Respiratory (Lungs)	**____None**	____Cough	____Shortness of Breath while sitting	
		____Wheezing	____Other:_____	
Cardiovascular (Heart)	**____None**	____Cyanosis	____Palpitations/Fluttering of Heart	
		____ Pain in Chest	____Shortness of Breath while exercising	
Gastrointestinal	**____None**	____Pain	**____**Constipation	____Diarrhea
		____Indigestion	____Other:_____	
Hematologic/Lymph Nodes	**____None**	____Bleeding Easily	____Night sweats	____Other:_____
Genitourinary	**____None**	____Hesitation when urinating		____Urination at Night
		____Pain when urinating		____Other:_____
Musculoskeletal	**____None**	____Cramping	____Soreness	____Weakness
		____Other:_____		
Integumentary	**____None**	**____**Dry Skin	____Itchy Skin	____Lesions on Skin
		____Bleeding	____Other:_____	
Neurological (Nerves)	**____None**	____ Dizziness/Vertigo	____Ringing in Ears	____Abnormal Movements
		____Twitch	____Other:_____	
Psychiatric	**____None**	____Situational Stress	____Depression	____Mood Swings
		____Anxiety	____Other:_____	
Endocrine	**____None**	**____**Hot Flashes	____Hair Loss/Growth	____Heat
		____Cold	____Other:_____	

Patient Comments: _____

_____

_____

Signature of Patient/Guardian _____Date_____