

Laurence R. O'Halloran, MD Timothy J. Egan, MD, Heinz H.E. Scheidemandel, MD, Antonio J. Cachay, MD Sarah Blank MD

Welcome to our office. Please complete these forms as completely and accurately as possible. We recommend saving the completed file first then e-mail using the e-mail button. The e-mail function however in some browsers doe not function optimally. In that case, please just e-mail the saved file to info@fairfaxent.com. Thanks!

PATIENT I						
atient's Last Name			First N	lame		Middle Initial
arent Name (if Patient	is a minor)					
Patient Age	Date of Birth	Sex:	Male	Female	Socia	al Security Number
1arital Status Singl	le Married	Divorced	Sep	parated	Widowed	
ome Address			City		State	Zip
rimary Phone		Secondary Phon	е		Other Phon	е
-Mail Address						
our Occupation		Your En	nployer			
Spouse Name		Spouse's	s Employe	r		
Whom May We Thank fo	or Referring You to Ou	ır Practice?				
NOTIFY IN	I CASE OF	<b>EMERGI</b>	ENCY	<b>(</b>		
lame			Relatio	nship		
Home Phone	,	Work Phone			Cellular Pho	ne
Nearest Relative (not li	ving with you)					
Home Phone	,	Work Phone			Cellular Pho	ne
WHO IS YO	OUR DOCT	OR? (PR	IMAR'	Y CARE	AND SPECIA	LIST)
Physician Name	Specialty	Address				,
	I	I				
Ciamakuwa .				Date:		
signature :				Date:		
Signature :				Date: _		
Signature: Signature: Signature: Signature:				Date: _		

	URANCE					
Primary Insurance Name		Telephone Number				
Claim Address		City	State Zip			
Policy Holder's Name	Relation To Patient	Policy Holder's Date of Birth	Subscriber's SS Numb			
Insurance ID	G	roup #				
SECONDARY I	NSURANCE					
Secondary Insurance Name		Telephone Nui	mber			
Claim Address		City	State Zip			
Policy Holder's Name	Relation To Patient	Policy Holder's Date of Birth	Subscriber's SS Number			
Insurance ID	G	roup #				
MY PHARMAC	Y					
Pharmacy Name	Location		Phone Number			
DATIENT DECE	ANCIDII ITV					
PATIENT RESE	PONSIBILITY					
Please read our Financial	Policy Statement and Ag	reement and sign below.				
Medical Records						
I authorize the use of this medical information to all		ce submissions. I authorize	the release of my			
<b>Payment and Collectio</b>	,	s ii mev so requesi.				
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MEDICAL HISTORY
What is the reason for your visit?
How long have you had the problem?
How severe is the problem?
Prior treatments

Name:

W	HAT	MEDICAL PROBLE	MS DO YOU HAVE?
NO	YES	PROBLEM	DATE / DETAILS
		Major Illness	
		Major Injury	
		Hospitalization	
		Acid Reflux	
		Anemia	
		Asthma	
		Bleeding / Bruising Problems	
		Blood Clots	
		Cancer	
		Diabetes	
		Heart Problems	
		High Blood Pressure	
		Kidney Problems	
		Liver Problems	
		Lung Problems	
		Thyroid Problems	
		CHILDREN ONLY	
		Born Premature	
		Congenital Defects	
		Reading/Learning Disability	
		WOMEN ONLY	
		Are you pregnant?	

NHA	T SURGERIE	<b>ES HAVE</b>	YOU HAD	?
O YES	PROCEDURE NAME		DATE	SURGEON / LOCATION
	Tonsillectomy			
	Adenoidectomy			
	Ear Surgery			
	Nose Surgery			
	Throat/Neck Surger			
_	Anesthesia Problems  OTHER Please list			
	OTHER Please list	•		
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Name:
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SC	CI	AL HISTORY / HABITS	s / RIS	K FAC	CTORS		
NO	YES	QUESTION	DETAILS				
		Tobacco:					
		Cigarettes	No packs/	day:			
		Cigars / Pipe / Chewing Tobacco	Quantity:				
		Have you ever smoked in the past?	Date start	ed:	Date	e stoppe	d:
		Alcohol:	Never	Rarely	Socially	Daily	Alcoholic
		Beer / Wine / Liquor					
		Drugs:					
		Cocaine / Marijuana /					
		Family:					
Chile	dren		Number:	Ag	es:		
Occi	upatio	on					·

FA	FAMILY HISTORY						
NO	YES	PROBLEM	RELATION	YEAR	FOR DOCTOR NOTES		
		Allergies					
		Asthma					
		Arthritis					
		Bleeding problems					
		Cancer					
		Diabetes					
		Heart Trouble					
		Mental Illness					
		Migraine headaches					
		Stroke					
		Thyroid Disease / Goiter					
		Tuberculosis					
		Ear Infections					
		Otosclerosis					
		Glaucoma					
		Hearing Loss					
		Other: please list:					
		-					

DO	DO YOU HAVE TROUBLE HEARING?				
No	Yes				
		Do you have trouble hearing in noisy environments?			
		Does anyone ever complain about your hearing?			
		Do you use or own hearing aids?			
		Have you ever been told that you would benefit from hearing aids?			

Name:		

DO	YO	U HAVE ANY OF THE	FC	LL	OWING SYMPTOMS?
NO	YES		NO	YES	
		CONSTITUTIONAL			GASTROINTESTINAL
		Weight Loss or Gain			Nausea/Vomiting
		Fatigue			Heartburn
		Fever/ Chills			Bowel Changes
		VOICE AND THROAT			Abdominal Pain
		Change in Voice			CARDIOVASCULAR
		Trouble Swallowing			Chest Pain
		Sore Throat			Leg Swelling
		EARS			URINARY / REPRODUCTIVE
		Hearing Loss			Do you think you could be pregnant now
		Ringing or ear noise			Difficulty urinating
		Pain in ears			MUSCULOSKELETAL
		Dizziness/Imbalance			Pain in Neck
		MOUTH AND NECK			Stiff Joints
		Lumps in neck			PSYCHIATRIC / EMOTIONAL
		Headaches			Anxiety
		Nosebleeds			Depression
		EYES			NEUROLOGIC
		Blurred Vision			Numbness
		Double Vision			Weakness/Paralysis
		RESPIRATORY			Tingling
		Cough			Difficulty Walking
		Wheezing			Skin
		Shortness of Breath			Itching/ Rash
		Coughing up Blood			Non healing lesion
		ENDOCRINE / METABOLIC			Hematological
		Heat or Cold Intolerance			Bleeding or Bruising
		Hair Change			Enlarged Lymph Nodes

## **Reviewed by Patient:**

Signature:	<u>.</u>	Date:	 •
Signature:	<u>.</u>	Date:	 :
Signature:	<u>.</u>	Date:	
Signature:	<u>.</u>	Date:	
Signature:		Date:	

**PHYSICIAN**: I have reviewed the PMH, SH, FH and ROS \_\_\_\_\_