PATIENT REGISTRATION
The New York Otolaryngology Group, P.C.
The Ear, Nose and Throat Specialists

Patient Name:_____ **S.S.#**_____
Last First

Referred By:_____

Reason for Visit:_____

_____

Primary Care Physician_____ Physician address:_____

Physician telephone:_____ _____

Medications ***list all medications you are taking***

ÿ None

_____

_____

_____

Allergies ***to medications or substances***

ÿ None

_____

_____

_____

PAST MEDICAL HISTORY *if yes (circle)*

Do you Smoke?_____ Did you smoke?_____ cigarettes, cigars, pipe
If you ever smoked, when did you stop?_____
Do you drink?_____ If so, how many drinks a day?_____
Do you or have you ever used IV drugs?_____

Past or Current Medical Illnesses: (circle)

Hypertension (high blood pressure)	Lung Disease (COPD, Asthma)	Bleeding Disorder	Thyroid Disease
Heart Disease	Arthritis	Neurological Disorder	Elevated Cholesterol
Diabetes	Environmental Allergies	Kidney Disease	Stroke
Cancer (type)_____		Glaucoma	
		Other_____	

Do you have a pacemaker?_____ **Do you have problems with hearing? Yes**____ **No**____

Hospitalizations/Surgeries:

Year	Hospital	Reason for Hospitalization/Type of Surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS *Do you experience (circle):*

Fever/chills	Muscle weakness	Palpitations	Frequent urination
Weight loss	Heartburn/indigestion	Chest pain	Pain with urination
Loss of appetite	Digestive Problems	Easy bruising	Depression
Shortness of Breath	Sinus problems	Arthritis/Joint Pain	
Dizziness/ imbalance	Eye problems	Headache	

FAMILY HISTORY *Have any of your blood relatives had (circle):*

Hypertension	Stroke	Cancer (type)_____	other_____
Heart Disease	Anemia	Autoimmune Disease	
Diabetes	Asthma	Hearing Loss	

_____ _____
Signature Date