West Texas
EAR, NOSE & THROAT

NOTICE TO PATIENTS:
Please fill out to the best of your ability, then sign & date.
Thank You,
ENT Staff

Patient Name: _____
Patient Date of Birth: _____ **Height:** _____ **Weight:** _____
Ins. Policy Holder SS#: _____

Who are you seeing today: **Dr. Jason Acevedo** **Amanda Duke, FNP-C** **Jessica Waller, FNP-C**

Primary Care Physician: _____
Pharmacy: _____
Drug Allergies: _____

Smoking:

_____ **Current (if YES, how many packs/cigarettes per day** _____**)**
_____ **Never**
_____ **Former**

Do you have any other Specialists you are under the care of?

Cardiologist: _____
Rheumatologist: _____
Pulmonologist: _____
Other: _____
_____

Past Surgeries:

Type of Surgery **Date of Surgery/Year**

_____
_____
_____
_____
_____
_____
_____

Current Medication List:

_____
_____
_____
_____
_____
_____
_____
_____

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Patient/Guardian Signature: _____ Date: _____

Past Medical History:

____NONE
____Age Related Macular Degeneration
____Allergic Rhinitis
____Asthma (Controlled? Yes/No)
____Autoimmune Disease
____Cancer (Type: _____)
____Cholesteatoma
____Congestive Heart Failure
____ Sleep Apnea/OSA
____Diabetes Mellitus Type 2 (Controlled? Yes/No)
____Gastroesophageal Reflux Disease
____Heart Disease
____ High Blood Pressure
____ HX of Hearing Loss (Hearing Aids? Yes/No)
____ Malignant Neoplasm of skin
____ Mastoiditis
____ Migraines
____ Nasal Obstruction
____ Sinusitis
____ Sjogren's Syndrome ____Depression
____ Thyroid nodule
____ Tinnitus
____ Tonsillitis

Other:_____

_____

Family Medical History

Cancer: ( ) YES ( ) NO
What type of Cancer? _____
( ) Mother / Father ( ) Maternal Grandmother / Grandfather ( ) Paternal Grandmother / Grandfather
( ) OTHER: _____

CAD: ( ) YES ( ) NO
( ) Mother / Father ( ) Maternal Grandmother / Grandfather ( ) Paternal Grandmother / Grandfather
( ) OTHER: _____

Diabetes: ( ) YES ( ) NO
( ) Mother / Father ( ) Maternal Grandmother / Grandfather ( ) Paternal Grandmother / Grandfather
( ) OTHER: _____

Bleeding Disorders: ( ) YES ( ) NO
( ) Mother / Father ( ) Maternal Grandmother / Grandfather ( ) Paternal Grandmother / Grandfather
( ) OTHER: _____

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Patient Name: _____

Patient DOB: _____

Appointment Date: _____

Please circle the following symptom(s) that you are currently having or have had in the last 2 weeks.

General:	Fever	Chills		
Eyes:	Eye Pain	Vision changes	Double Vision	
Ears:	Difficulty hearing	Ear pain	Ringing in ears	Ear drainage
Nose:	Bleeding nose	Nasal congestion	Runny nose	
Mouth/Throat:	Sore throat	Difficulty Swallowing	Mouth sores	
	Postnasal drip			
Cardiovascular:	Chest Pain	Palpitations		
Respiratory:	Cough	Wheezing	Shortness of Breath	
Gastrointestinal:	Abdominal Pain	Heartburn	Nausea/Vomiting	
Neurologic:	Dizziness	Headache		
Allergy:	Sinus pressure	Rash	Excessive sneezing	