PATIENT HISTORY DATA SHEET

Fayette Ear, Nose, Throat & Allergy/Ravi Nadarajah, MD, BDS, MSC, FAAOA, FACS
110 Daniel Drive; Suite 14; Uniontown, PA 15401

NAME_____ **AGE**_____ **TODAY'S DATE**_____

BIRTH DATE_____ **FAMILY PHYSICIAN**_____

HOW DID YOU HEAR ABOUT US? BILLBOARD www.FayetteENTandAllergy.com INTERNET TV ADVERTISEMENT PHYSICIAN FRIEND RELATIVE OTHER: Specify_____

ALLERGIES TO MEDICATIONS: NO YES **LATEX ALLERGY:** NO YES
(Please List):

CURRENT MEDICATIONS: NO YES **(Please List):**

(FEMALES) ARE YOU PREGNANT? NO YES **ARE YOU BREASTFEEDING?** NO YES

PREVIOUS SURGERY: NO YES **(Please List):**

RECENTLY HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS:
(Please Circle Yes or No)

General
Yes No weakness or fatigue
Yes No recent weight loss

Eyes
Yes No blurred vision
Yes No double vision

Ears, Nose, Mouth and Throat
Yes No hearing trouble
Yes No tinnitus or ringing in ears
Yes No ear pain
Yes No ear infection or drainage
Yes No dizziness, vertigo or unsteadiness
Yes No stuffy nose
Yes No sinus trouble
Yes No frequent nose bleeds
Yes No frequent sore throats
Yes No pain near teeth or mouth
Yes No hoarseness or voice change
Yes No difficulty swallowing
Yes No lumps in neck
Yes No pain in the neck

Cardiovascular
Yes No heart trouble
Yes No palpitations
Yes No high blood pressure

Respiratory
Yes No cough
Yes No asthma or wheezing
Yes No shortness of breath

Hematologic
Yes No easy bruising or bleeding
Yes No anemia

Allergic
Yes No hay fever or dust/mold allergy
Yes No food sensitivity or intolerance
Yes No chemical sensitivity

Gastrointestinal
Yes No heartburn or acid reflux
Yes No nausea or vomiting
Yes No diarrhea
Yes No ulcers
Yes No frequent use of antacids

Genitourinary
Yes No kidney problems

Musculoskeletal
Yes No joint pain or stiffness

Integmentary
Yes No skin rashes

Neurological
Yes No headaches
Yes No numbness in face, legs or arms
Yes No seizures
Yes No weakness of arms or legs
Yes No blackouts or fainting
Yes No trouble speaking
Yes No confusion or memory loss

Psychiatric
Yes No nervousness or increased stress
Yes No sleep problems
Yes No excessive moodiness or worry

Endocrine
Yes No thyroid trouble
Yes No diabetes

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NAME_____ **BIRTH DATE**_____

PAST MEDICAL HISTORY

Do You have or ever had.....

Yes	No	heart disease (heart attack, angina, heart surgery, arrhythmia)	Yes	No	stroke or TIA
			Yes	No	migraine headaches
Yes	No	diabetes (insulin, pills, controlled by diet)	Yes	No	seizure
Yes	No	lung disease (asthma, emphysema, chronic bronchitis)	Yes	No	anxiety disorder
			Yes	No	depression
Yes	No	high blood pressure	Yes	No	panic attacks
Yes	No	thyroid problems	Yes	No	arthritis
Yes	No	kidney trouble	Yes	No	glaucoma
Yes	No	cancer	Yes	No	macular degeneration
Yes	No	liver or gallbladder trouble	Yes	No	Use of alternative medicine (please list):
Yes	No	head trauma			

SOCIAL HISTORY

Occupation/Job: _____ or is patient a minor? Yes No
(must be answered)

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____ Not Applicable____

Children: How Many_____ Ages: _____ Not Applicable____

Please circle answer Do you use tobacco? **Current** **Former** **Never**
(**Heavy** smoker or **Light** smoker)

Yes No Do you use alcohol (_____drinks per day/week/weekend/month)

Yes No Do you use coffee, tea or caffeine containing beverages (_____ cups per day)

FAMILY HISTORY

If any blood relatives have had any of the following, please circle and indicate which relative

heart disease	migraines	mental illness	epilepsy
diabetes	thyroid problems	voice problems	bleeds easily
hearing loss	stroke	dizziness	cancer
hereditary disorder:_____			

I understand the importance of follow-up and compliance with medical treatment rendered by Dr. Nadarajah to achieve the best optimal outcome for my condition.

_____
Patient/Legal Guardian Signature

___ROS, PMHx, FHx, SHx completed by patient & reviewed by MD_____
Physician Signature

Revised 2/27/15

Date_____

Fayette Ear, Nose, Throat and Allergy
Ravi Nadarajah, MD, BDS, MSC, FAAOA, FACS
160 Wayland Smith Drive; Suite 204
Uniontown, PA 15401
(724) 430-0310

Information Security and Acknowledgement of Privacy Practices

Is the primary telephone number provided to us by you a residence or a cell phone?

*Residence*_____ *Cell*_____

Are we permitted to leave a message/voice mail? _____*YES* _____*NO*

May we speak to anyone in your household/family regarding your healthcare?

_____***YES**, you may speak to anyone in my family regarding my healthcare*
*(if you wish you may list someone)*_____

_____***NO**, you may not speak to anyone in my family regarding my healthcare*

Privacy and trust are important to us. Certain health information will be disclosed during the medical exam. I understand that any individual(s) accompanying me into the exam room will have access to all information exchanged during that consultation and has my consent to be present during the entire visit.

I acknowledge I have received a copy of this practices Privacy Policies

Date_____

_____
(Printed Name of Individual)

_____
(Signature of Individual or Representative)

_____
(Staff Witness)

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FAYETTE EAR, NOSE, THROAT AND ALLERGY, PC
RAVI NADARAJAH, MD, BDS, MSc, FAAOA, FACS

110 Daniel Drive; Ste. 14
Uniontown, PA 15401
(724) 430-0310

NAME_____ DATE OF BIRTH_____ TODAY'S DATE_____

Considering how severe the problem is when you experience it and how frequently it happens. Rate each item below on how "bad" it is by circling the number that corresponds with how you feel.

	No Problem	Very Mild	Mild or Slight	Moderate	Severe	As Bad As It Can Be
Need to blow nose	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Runny Nose	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Post nasal discharge	0	1	2	3	4	5
Thick nasal discharge	0	1	2	3	4	5
Ear fullness	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Ear pain	0	1	2	3	4	5
Facial pain/pressure	0	1	2	3	4	5
Difficult falling asleep	0	1	2	3	4	5
Waking up at night	0	1	2	3	4	5
Lack of a good night's sleep	0	1	2	3	4	5
Waking up tired	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5
Reduced productivity	0	1	2	3	4	5
Reduced concentration	0	1	2	3	4	5
Frustrated/restless/irritable	0	1	2	3	4	5
Sad	0	1	2	3	4	5
Embarrassed	0	1	2	3	4	5
Sense of taste/smell	0	1	2	3	4	5
Blockage/congestion of nose	0	1	2	3	4	5

ADD each column and TOTAL _____ _____ _____ _____ _____

GRAND TOTAL_____/110

_____
Ravi Nadarajah, MD, BDS, MSc, FAAOA, FACS