Crossville Location:
49 Cleveland St,
Suite 220
Crossville, TN 38555
Main: 931-219-9990
Fax: 931-717-1180

Oak Ridge Location
700 S. Illinois Ave, Suite
A104
Oak Ridge, TN 37830
Main: 865-383-0737
Fax: 865-383-0015

# Patient Interview Form

## PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____

Email: _____ Phone Number: _____

**Contact Preference**

☐ Home phone ☐ Cell phone ☐ Email ☐ Patient declines to specify

**Sex**

☐ Male ☐ Female ☐ Other

**Race** - Select one or more

☐ White ☐ Black or African American ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Unknown
☐ Patient declines to specify

**Ethnicity**

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

**Preferred Language**

☐ English ☐ Russian ☐ Spanish; Castilian ☐ Patient declines to specify

**Allergies**

☐ Patient has no known allergies ☐ Patient has no known drug allergies
☐ Penicillin sulfa (sulfonamide antibiotics) ☐ Aspirin ☐ Vicodin ☐ Codeine
☐ Propofol analogues ☐ Iodine ☐ Other _____

**Current Medications** (Including prescription, over-the-counter, and herbs/supplements)

☐ NONE

Name Dose

_____

_____

_____

_____

_____

_____

_____

ROCKY TOP ENT & ALLERGY

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**Past or Present Medical Conditions**

| | | | |
|---|---|---|---|
| ☐ NONE | ☐ Acid Reflux | ☐ Barrett's Esophagus | ☐ Esophageal Narrowing/Strictures |
| ☐ Hepatitis | ☐ Glaucoma | ☐ Cataracts | ☐ Anxiety |
| ☐ Allergies | ☐ Sinusitis | ☐ Migraine | ☐ Depression |
| ☐ Sleep Apnea | ☐ Throat Cancer | ☐ Breast Cancer | ☐ Lung Cancer |
| ☐ Skin Cancer | ☐ Prostate Cancer | ☐ Colon Cancer | ☐ Other Cancer: _____ |
| ☐ High Blood Pressure | ☐ High Cholesterol | ☐ Stroke | ☐ Heart Attack |
| ☐ Diabetes | ☐ Anemia | ☐ Hemophilia | ☐ Other Bleeding Disorder: _____ |
| ☐ Blood Clots/DVT | ☐ Thyroid Disorder | ☐ Kidney Failure | ☐ Fibromyalgia |
| ☐ Asthma | ☐ COPD | ☐ Tuberculosis | ☐ HIV |

☐ OTHER: _____

**Previous Procedures**

☐ NONE

Name Date Complications?

_____

_____

_____

_____

_____

_____

_____

Have you ever had any problems with anesthesia? ☐ No ☐ Yes: _____

**Diagnostic Studies/Tests**

☐ NONE

☐ Allergy Testing
Date: _____

☐ Swallow study (Modified Barium Swallow or Esophagram?)
Date and Location: _____

☐ MRI of head/neck
Date and Location: _____

☐ Thyroid or neck ultrasound
Date and Location: _____

☐ CT scan of sinuses/face head or neck
Date and Location: _____

Occupation: _____ Marital Status: _____

**Alcohol**

☐ NONE
☐ Less than seven drinks weekly, and no more than three drinks on any one occasion
☐ More than seven drinks weekly, and/or more than three drinks on any one occasion
☐ Less than 14 drinks weekly and no more than four drinks on any one occasion
☐ More than 14 drinks weekly and/or more than four drinks on any one occasion
☐ Former alcohol abuse, now sober

**Tobacco - Smoking Status**

| | | |
|---|---|---|
| ☐ Current every day smoker | ☐ Current some day smoker | ☐ Former smoker |
| ☐ Never a smoker | ☐ Smoker, current status unknown | ☐ Light tobacco smoker |
| ☐ Heavy tobacco smoker | ☐ Unknown if ever smoked | |

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**Drug Use**

☐ None ☐ Past use of drugs ☐ Current use of drugs
Type: _____

**Caffeine Use**

☐ None ☐ 1 cup per day ☐ 2-3 cups per day ☐ 4 or more cups per day

**Family Medical History**

☐ No known knowledge of family history

Please provide the following information with regard to your relatives:
If living, age, state of health/illnesses; if deceased, age and cause of death

Mother _____

Father _____

Siblings _____

Children _____

Other Family _____

**Review of Systems**

| ABDOMINAL PAIN | Y | N |
|---|---|---|
| ☐ None | | |
| Abdominal distension, bloating | ☐ | ☐ |
| Nighttime awakening from abdominal pain | ☐ | ☐ |
| Abnormal bowel movements | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Loose stools | ☐ | ☐ |
| Recent changes in bowel habits | ☐ | ☐ |
| Bloody diarrhea | ☐ | ☐ |
| Rectal bleeding | ☐ | ☐ |
| Black, tarry stools | ☐ | ☐ |
| Rectal pain | ☐ | ☐ |
| Fecal incontinence | ☐ | ☐ |
| Heartburn | ☐ | ☐ |
| Nausea | ☐ | ☐ |
| Vomiting | ☐ | ☐ |
| Belching | ☐ | ☐ |
| Vomiting blood | ☐ | ☐ |
| Gas | ☐ | ☐ |

| ALLERGIC IMMUNOLOGIC | Y | N |
|---|---|---|
| ☐ None | | |
| Persistent infections | ☐ | ☐ |

| CARDIOVASCULAR | Y | N |
|---|---|---|
| ☐ None | | |
| Chest pain | ☐ | ☐ |
| Irregular heart beat | ☐ | ☐ |
| Syncope | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |

| MUSCULOSKELETAL | Y | N |
|---|---|---|
| ☐ None | | |
| Arthritis | ☐ | ☐ |
| Back pain | ☐ | ☐ |
| Joint pain | ☐ | ☐ |
| Stiffness | ☐ | ☐ |
| Swelling | ☐ | ☐ |

| ENDOCRINE | Y | N |
|---|---|---|
| ☐ None | | |
| Excessive thirst | ☐ | ☐ |
| Heat intolerance | ☐ | ☐ |
| Cold intolerance | ☐ | ☐ |
| Excessive urination | ☐ | ☐ |

| EYES | Y | N |
|---|---|---|
| ☐ None | | |
| Yellowing of eyes | ☐ | ☐ |
| Redness of eyes | ☐ | ☐ |

| GENITOURINARY | Y | N |
|---|---|---|
| ☐ None | | |
| Dark urine | ☐ | ☐ |
| Dysuria | ☐ | ☐ |
| Frequent urination | ☐ | ☐ |
| Urinary incontinence | ☐ | ☐ |
| Urgency | ☐ | ☐ |
| Heavy menstrual periods | ☐ | ☐ |

| HEMATOLOGIC/LYMPHATIC | Y | N |
|---|---|---|
| ☐ None | | |
| Easy bruising | ☐ | ☐ |
| Prolonged bleeding | ☐ | ☐ |
| Swollen lymph nodes | ☐ | ☐ |
| Recent anemia | ☐ | ☐ |

| INTEGUMENTARY | Y | N |
|---|---|---|
| ☐ None | | |
| Itching | ☐ | ☐ |
| Yellowing of skin | ☐ | ☐ |
| Lesions | ☐ | ☐ |
| Rashes | ☐ | ☐ |

| NEUROLOGICAL | Y | N |
|---|---|---|
| ☐ None | | |
| Dizziness | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Confusion | ☐ | ☐ |

| PSYCHIATRIC | Y | N |
|---|---|---|
| ☐ None | | |
| Anxiety | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Nervousness | ☐ | ☐ |
| Agitation | ☐ | ☐ |

| RESPIRATORY | Y | N |
|---|---|---|
| ☐ None | | |
| Cough | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |

| CONSTITUTIONAL | Y | N |
|---|---|---|
| ☐ None | | |
| Fatigue | ☐ | ☐ |
| Fever | ☐ | ☐ |
| Chills | ☐ | ☐ |
| Sweats | ☐ | ☐ |
| Loss of appetite | ☐ | ☐ |
| Weight loss | ☐ | ☐ |

| ENMT | Y | N |
|---|---|---|
| ☐ None | | |
| Difficulty swallowing | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Sinus pain | ☐ | ☐ |
| Ringing in the ears | ☐ | ☐ |
| Hoarseness | ☐ | ☐ |
| Neck swelling | ☐ | ☐ |

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**Consent to Import Medication History**

I consent to obtaining a history of my medications purchased at pharmacies.

☐ Yes ☐ No

**Reminder Preference**

I would like to receive preventative care and follow-up care reminders. ☐ Yes ☐ No

**Patient Contact Information Restriction**

The HIPAA privacy rule gives you the right to request a restriction on uses and disclosures of your Protected Health Information.

I wish to be contacted in the following manner **(please check all that apply)**:

☐ Home Phone ( _____ ) _____ - _____
- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with callback number only

☐ Cell Phone ( _____ ) _____ - _____
- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with callback number only

☐ Work Phone ( _____ ) _____ - _____
- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with callback number only

☐ I hereby consent to the release of my medical information to the people listed below. The authorization will be in effect until I change it.

☐ I hereby decline the release of my medical information to anybody. This authorization will be in effect until I change it.

| Name | Relationship |
|---|---|
| | |
| | |
| | |

**Pharmacy**

Name Address Phone

**Reviewed with**

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature Date