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GENERAL INFORMATION:

Today's Date: ___ / ___ / ___

Patient's Name: _____ Date of Birth: ___ / ___ / ___

Address: _____

Parent /Guardian's Name: _____

Address: _____

Phone: Home: () _____ Cell: () _____ Work: () _____

Does the above person have the legal authority to make medical decisions? [] yes [] no If NO, whom? _____

If we need to contact you, which is the preferred number? [] Home [] Cell [] Work

Can we leave a message at this number on the answering machine? [] yes [] no

Parent or Guardian's Email address: _____

Preferred Pharmacy (Name & Address): _____

Government regulations require we ask for the following identifying information for the patient.

Gender: [] Male [] Female
Race: [] Caucasian [] African American [] Hispanic [] Russian [] Other: _____
Ethnicity: [] Non-Hispanic [] Hispanic
Primary/Preferred Language: [] English [] Spanish [] Other: _____

REFERRING DOCTOR:

Did a doctor send you and do you want us to send the doctor a report about today's visit? [] yes [] no

Doctor's Name: _____ Primary Care Doctor's Name: _____

PEDIATRIC REVIEW OF SYSTEMS: (Please check boxes to indicate "YES" or "NO".)

Y / N General/Constitutional:

- [] Change in Appetite
[] Chills
[] Fever
[] Weight Loss
[] Excessive Bruising / Bleeding

- [] Speech Problems
[] Language Delays
[] Mouth Breathing
[] Snoring / Noisy Breathing
[] Hoarseness/voice change
[] Frequent Nose Bleeds
[] Passed Newborn Hearing Screening Test

Y / N Cardiovascular:

- [] Chest Pain at Rest
[] Irregular Heartbeat

Y / N Musculoskeletal:

- [] Painful Joints
[] Swollen Joints

Y / N Ophthalmologic (Eyes):

- [] Blurred Vision
[] Pink Eye / Conjunctivitis
[] Vision Problems

Y / N Skin:

- [] Itching
[] Rashes

Y / N Ear, Nose and Throat:

- [] Frequent Ear Infections
[] Frequent Sinus Infections
[] Frequent Strep Throat / Tonsillitis
[] Decreased Hearing
[] Ringing in Ears

Y / N Respiratory:

- [] Cough
[] Shortness of Breath (at rest)
[] Wheezing

Y / N Gastrointestinal:

- [] Abdominal Pain
[] Diarrhea
[] Vomiting
[] GERD / Heartburn

Y / N Neurologic:

- [] Dizziness
[] Headaches

Y / N Genitourinary:

- [] Blood in Urine
[] Painful Urination
[] Bedwetting

PAST MEDICAL HISTORY: (Please check boxes to indicate "YES" or "NO".)

Indicate if you have any of the medical problems listed below and add any additional problems not covered in the space provided.

Y/N

- Down's Syndrome
- Autism
- Learning Disorder
- ADHD / Hyperactivity
- Environmental Allergies
- Premature Birth
- Recurrent / Frequent Croup
- Heart Defect
- Heart Murmur
- Heart / Thoracic Surgery
- Asthma
- Pneumonia

Y/N

- GERD
- Kidney / Renal Disease
- History of Cancer:
Type: _____
- Diabetes
- Bleeding Disorders
- Thyroid Disease
- History of Migraine Headaches
- Immune Deficiency
- Seizures
- Eczema
- Other: _____

SOCIAL HISTORY:

Is the patient in daycare? yes no

Is there smoke exposure at home? yes no

Are the patient's immunizations up to date? yes no

Does the patient have brothers and/or sisters? yes no If YES, how many? _____

FAMILY HISTORY: (Please check boxes to indicate "YES" or "NO".)

Y/N Do any of these diseases run in your family:

- Diabetes
- Heart Disease
- Anesthesia Complications
- Cancer
- Bleeding Disorders
- Other: _____

PAST SURGICAL HISTORY: Please list previous surgeries.

CURRENT MEDICATIONS: Please indicate doses and how often you take.

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
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ALLERGIES TO MEDICATIONS:
