BaylorScott&White
ENT ASSOCIATES
GRAPEVINE
A member of HealthTexas Provider Network

MRN #:____________________

Patient Name:______________________________ Age:__________ Date of Birth:______________

Reason for visit: ____

Medical Doctor or Primary Care Physician	Referring Physician
Name:______________________ MD/DO	Name:______________________ MD/DO
Street:______________________	Street:______________________
City/State:______________________	City/State:______________________
Phone #: ( ) -	Phone #: ( ) -

HT:__________ WT:__________

List **ALL MEDICATIONS** being taken now, including over-the-counter medications. Please attach list if necessary :

Medication Name	Dose and Frequency	Ordering Doctor

Allegies to Medications:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Pharmacy Name:______________________

Phone #:______________________

Patient Name:____ **Date of Birth:**____________________

Past Medical History:

Y N Autoimmune Disorder

Y N Blood Transfusion Date: ________

Y N Colon Cancer

Y N Depression

Y N Diabetes Type 1

Y N Diabetes Type 2

Y N Blood Clots – DVT Date: ________

Y N Hepatitis B

Check all Medical Conditions you have:

Y N Hepatitis C

Y N Hypertension

Y N Thyroid Disease

Y N Liver Disease

Y N Osteoarthritis

Y N Stroke – CVA

Y N Seizure Disorder

Other: ______________________________

Past Surgical History:

Surgery:	Date:

Family History:

	Age	Living or Deceased	Health Problems or Cause of Death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

Patient Name:______________________ **Date of Birth:**______________________

Where is the pain? Does it radiate or go anywhere else? ______________________

____

How did the pain start? ______________________

____

How long has the pain been present? ______________________

____

Is your pain: ☐ Constant ☐ Intermittent

On a scale of 0 to 10 (0 = no pain, 10 = worst pain), how severe is the pain on average? ______________________

What makes your pain better: ______________________

What makes your pain worse? ______________________

How would you describe the pain? (Please circle)

THROBBING **SHOOTING** **STABBING** **ACHING** **RINGING** **SHARP** **TENDER**

Associated Symptoms: (Please check all that apply)

☐ Dizziness ☐ Room Spinning ☐ Vomiting ☐ Snoring

☐ Nausea ☐ Issues with Swallowing ☐ Pressure ☐ Bleeding

☐ Hearing Loss ☐ Sensitive of Light ☐ Congestion ☐ Sinus Headaches

☐ Drainage ☐ Other: ______________________