

**LAKE GROVE ENT, P.C.**

MAUREEN MULCAHY, MD • ROBERT FURMAN, MD • MICHELLE VESSELY, MD • CAROLINE YANG, MD  
 ERIKA SCHETTLER-HUBERTY, MD • KIMBERLY LAVOIE AU. D, CCC-A • NANCY HENSON, AU. D, CCC-A

Todays Date: \_\_\_\_\_  
 Doctor you are seeing today: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male:  Female:   
 Primary Care Physician: \_\_\_\_\_  
 Is there a Referring Physician or Provider? \_\_\_\_\_

If not referred by a doctor, how did you hear about our office? \_\_\_\_\_

What is the primary reason for your visit with the doctor? \_\_\_\_\_

**PHARMACY YOU WOULD LIKE TO USE:** \_\_\_\_\_

**PAST MEDICAL HISTORY** Yes No  
 Do you have any medical problems?    
 Please List: \_\_\_\_\_

**HAVE YOU EVER HAD CANCER?** Yes No  
 If so, what type?   \_\_\_\_\_

**HAVE YOU EVER HAD SURGERY?** Yes No  
 Please List:   \_\_\_\_\_

**MEDICATIONS**  
 Please list any medications that you take on a regular basis.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LATEX ALLERGY** Yes No  
   
**DRUG ALLERGIES**    
 Please List: \_\_\_\_\_

**SOCIAL HISTORY**  
 Occupation / Retired: \_\_\_\_\_  
 Marital status: \_\_\_\_\_

**HABITS** Yes No  
 Have you ever used tobacco products?    
 How many years? \_\_\_\_\_  
 How many packs per day? \_\_\_\_\_  
 Have you stopped?    
 If yes, how long ago? \_\_\_\_\_

**DRINK ALCOHOL?**    
 How much? \_\_\_\_\_

Current illicit drug use? Yes No  
   
 If yes, what drug (s)? \_\_\_\_\_

**FAMILY HISTORY**

**ANY FAMILY HISTORY OF THE FOLLOWING** Yes No  
 Heart Disease    
 Arthritis    
 Cancer    
 Diabetes    
 Bleeding tendencies    
 Other: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you currently have any of the following symptoms?

**CONSTITUTIONAL SYMPTOM** Yes No  
 Fever    
 Chills    
 Lethargy    
 Weight gain / loss

**EYES** Yes No  
 Blurred vision    
 Double vision

**RESPIRATORY** Yes No  
 Wheezing    
 Frequent cough    
 Shortness of breath    
 History of Asthma

**CARDIOVASCULAR** Yes No  
 Chest pain    
 Rhythm problem    
 High blood pressure    
 Heart attack

**GASTROINTESTINAL** Yes No  
 Abdominal pain    
 Nausea / vomiting    
 Indigestion / heartburn

**NEUROLOGICAL** Yes No  
 Dizzy spells    
 Numbness / tingling    
 History of stroke    
 Seizure history

**ENDOCRINE** Yes No  
 Excessive thirst    
 Too hot / cold    
 History of diabetes    
 Thyroid problems

**HEMATOLOGIC / LYMPHATIC** Yes No  
 Anemia    
 Blood clotting problem    
 Easy bruising    
 Swollen nodes    
 Had a transfusion?    
 History of Hepatitis?

**ALLERGIC / IMMUNOLOGIC** Yes No  
 Itchy eyes / nose    
 Runny nose    
 Pets in the home    
 Immune disorder    
 Women – could you be pregnant?

HT/WT: \_\_\_\_\_ BP: \_\_\_\_\_  
 TEMP: \_\_\_\_\_ PULSE: \_\_\_\_\_