



# **EAR, NOSE, THROAT AND ALLERGY CENTER**

**EDITH A. MCFADDEN, MD, MA, FAAOA - DIRECTOR**

Diplomate, American Board of Otolaryngology  
Fellow, American Academy Otolaryngology/Head and Neck Surgery and American Academy Otolaryngic Allergy  
Member, American Rhinologic Society

## **PATIENT INFORMATION SHEET**

PATIENT NAME (first) \_\_\_\_\_ (middle) \_\_\_\_\_ (last) \_\_\_\_\_ DATE OF BIRTH   /  /  

PATIENT AGE \_\_\_\_\_ PATIENT SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TELEPHONE (home) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (work) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PARENTS' NAMES: MOTHER

(first) \_\_\_\_\_ (maiden) \_\_\_\_\_

FATHER

(first) \_\_\_\_\_ (last) \_\_\_\_\_

LEGAL GUARDIAN

(first) \_\_\_\_\_ (last) \_\_\_\_\_

PHYSICIAN WHO RECOMMENDED THIS CONSULTATION \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

INSURANCE NAME \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ TELEPHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_

**NO SMOKING POLICY:** I understand that no smoking is permitted in this office.

**MEDICAL CONSENT:** I, the undersigned, hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of the **EAR, NOSE, THROAT AND ALLERGY CENTER** for the patient identified above.

**FINANCIAL AGREEMENT AND ASSIGNMENT:** I, the undersigned, agree, whether signing as agent or as patient, that I am financially responsible for all charges incurred. Assignment of commercial insurance benefits to **EAR, NOSE, THROAT AND ALLERGY CENTER** does not reduce the responsibility for payment. Should this account be referred to any attorney for collection, the undersigned shall also be responsible for reasonable attorneys' fees and any additional fees associated with the collection process. Further, by signing below, I authorize payment to be made directly to **EAR, NOSE, THROAT AND ALLERGY CENTER** and/or EDITH A. MCFADDEN, M.D. for the benefits otherwise payable to me by any third party including any major medical benefits. I also agree to be billed directly and to pay for any administrative fees incurred from missed appointments or those I do not cancel or reschedule at least 24 hours in advance.

**MEDICAL CLAIMS:** I request that payment of authorized Medicare benefits, if applicable, be made either to me or on my behalf to **EAR, NOSE, THROAT AND ALLERGY CENTER** for any services furnished me by that provider.

PATIENT OR GUARDIAN SIGNATURE: \_\_\_\_\_

Today's Date:   /  /



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## **PATIENT INFORMATION SHEET**

PATIENT SIGNATURE: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_y.o. Today's Date: \_\_\_/\_\_\_/\_\_\_

THE FOLLOWING ARE A NUMBER OF QUESTIONS DESIGNED TO HELP DR. MCFADDEN UNDERSTAND YOUR PRESENT PROBLEMS AND ANY PREVIOUS HEALTH PROBLEMS YOU HAVE HAD, AS WELL AS YOUR LIFESTYLE. THIS WILL HELP MAXIMIZE THE CARE YOU RECEIVE. PLEASE FILL OUT **BOTH** SIDES OF THE QUESTIONNAIRE. THANK YOU.

### **A. WHY ARE YOU (OR YOUR CHILD) HERE TODAY TO SEE DR. MCFADDEN?**

List each complaint and when it started. and what, if anything, makes it better or worse.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### **B. General Allergy Symptoms: (List the three worst symptoms)**

- |   |  |  |  |
|---|--|--|--|
| 1.) _____   | 2.) _____  | 3.) _____  |  |
| <input type="checkbox"/> Worse or better outdoors | <input type="checkbox"/> Worse or better indoors       | <input type="checkbox"/> Worse 30 minutes after lying down | <input type="checkbox"/> Worse after lights are on 1 hr. |
| <input type="checkbox"/> Worse on windy days      | <input type="checkbox"/> Worse in warm or cool air     | <input type="checkbox"/> Worse when sweeping               | <input type="checkbox"/> Worse in certain rooms          |
| <input type="checkbox"/> Worse on clear days      | <input type="checkbox"/> Worse with temperature change | <input type="checkbox"/> Worse when dusting                | <input type="checkbox"/> Worse near a barn               |
| <input type="checkbox"/> Worse outdoors in AM     | <input type="checkbox"/> Worse in cold weather         | <input type="checkbox"/> Worse in low, damp area           | <input type="checkbox"/> Worse around animals            |
| <input type="checkbox"/> Worse outdoors in PM     | <input type="checkbox"/> Worse on cool evenings        | <input type="checkbox"/> Worse mowing or playing in grass  | Which ones _____   |

Are your symptoms constant or intermittent (off and on)? \_\_\_\_\_

During which seasons do you have symptoms? \_\_\_\_\_ During which months are symptoms most severe? \_\_\_\_\_

### **C. Medical History (check the following medical conditions you are experiencing or have experienced in the past):**

- |  |                                       |  |   |  |  |
|--|---------------------------------------|--|---|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hayfever     | <input type="checkbox"/> Sinus disease         | <input type="checkbox"/> Croup          | <input type="checkbox"/> Stomach/Intestine disease | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Drug allergy | <input type="checkbox"/> Sinus headaches       | <input type="checkbox"/> Skin disease   | <input type="checkbox"/> Liver disease             | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Milk allergy | <input type="checkbox"/> Migraine headaches    | <input type="checkbox"/> Ulcers         | <input type="checkbox"/> Kidney disease            | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Hives        | <input type="checkbox"/> Broken nose           | <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Thyroid disease           | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Deviated nasal septum | <input type="checkbox"/> Colitis        | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Other _____     |

List All Surgeries and

Hospitalizations: \_\_\_\_\_

Please List All Medicines You Take Now \_\_\_\_\_

Are you using contraception methods? (If so, which type?) \_\_\_\_\_ Last menstrual period \_\_\_\_\_

Which medicines relieve your allergy symptoms? \_\_\_\_\_

Please list all over-the-counter vitamins, etc. you take regularly: \_\_\_\_\_



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Please list any medicines you are allergic to:

### **D. Environmental Exposures:**

**Home:** Type \_\_\_\_\_ Attached garage? Yes \_\_\_ No \_\_\_ How old? \_\_\_\_\_ yrs. How long have you lived there? \_\_\_\_\_ yrs.  
City/Suburban/small town/rural? \_\_\_\_\_  
Type of heating and ventilation system? \_\_\_\_\_ Washer & dryer location: \_\_\_\_\_ gas/electric?  
Hot water heater location? \_\_\_\_\_ gas/electric? Wall-to-wall carpeting? No \_\_\_ Yes \_\_\_ (which rooms? \_\_\_\_\_)  
Any pets at home? No \_\_\_ Yes \_\_\_ (kind? \_\_\_\_\_) Do you use a HEPA room air purifier? No \_\_\_ Yes \_\_\_ (which room(s) \_\_\_\_\_)  
Do you use air conditioning? \_\_\_ No \_\_\_ Yes (which rooms? \_\_\_\_\_)

**PLEASE COMPLETE THE REST OF THE QUESTIONNAIRE ON THE OTHER SIDE OF THIS PAGE.**

PATIENT NAME \_\_\_\_\_

### **E. Social History:**

Do you live alone? Yes \_\_\_ No \_\_\_ (number of people and relationship \_\_\_\_\_)  
**Smoking habits:** cigarette # \_\_\_\_\_ /day; Pipe # \_\_\_\_\_ /day;# Cigar # \_\_\_\_\_ /day; Chewing tobacco or snuff? \_\_\_\_\_ /day. # Years smoked/chewed/sniffed? \_\_\_\_\_  
Stopped using tobacco in 19\_\_\_\_. **Alcohol use:** No \_\_\_ Yes \_\_\_ (# glasses wine/beer/liquor/day \_\_\_\_\_)  
**Other recreational drug use?** No \_\_\_ Yes \_\_\_ (kind \_\_\_\_\_) **Occupation:** \_\_\_\_\_  
**Check the following that apply:** \_\_\_ Divorced \_\_\_ Separated \_\_\_ Family problems \_\_\_ School problems \_\_\_ Frequent absence from school/work \_\_\_ Over-anxious

### **F. Family Medical History:** (list all serious medical problems your blood relatives have or died from and what their relationship is to you.)

\_\_\_ Asthma; \_\_\_ Allergies; \_\_\_ Tuberculosis; \_\_\_ Cancer; \_\_\_ Bleeding problems; \_\_\_ General anesthesia problems; \_\_\_ Other \_\_\_\_\_

## **SYSTEMS REVIEW**

**A. General:** Eyes \_\_\_ water, \_\_\_ itch \_\_\_ swell, \_\_\_ burn. Ears \_\_\_ drain or feel \_\_\_ blocked, \_\_\_ itchy, \_\_\_ sore. Nose feels \_\_\_ stuffy, \_\_\_ runny, \_\_\_ itchy.

Mouth feels \_\_\_ itchy, \_\_\_ ulcerated, \_\_\_ sore. \_\_\_ Sneeze; \_\_\_ Cough; \_\_\_ Fatigue; \_\_\_ Fever; \_\_\_ Sleep disturbance; \_\_\_ Weight loss (amount \_\_\_ lbs.); \_\_\_ Night sweats; \_\_\_ Nose bleeds; \_\_\_ Frequent sore throats; \_\_\_ Frequent colds. \_\_\_ Hoarseness. \_\_\_ Thirst. \_\_\_ Blurred vision.

**B. Stomach and Intestines:** Appetite \_\_\_ good, \_\_\_ picky, \_\_\_ poor. Bowels \_\_\_ regular, \_\_\_ constipated. Stools \_\_\_ normal, \_\_\_ diarrhea, \_\_\_ solid, \_\_\_ mucus.

\_\_\_ Halitosis; \_\_\_ Swallowing problems; \_\_\_ Choking feeling; \_\_\_ Nausea; \_\_\_ Vomiting; \_\_\_ Indigestion; \_\_\_ Gas; \_\_\_ Bloating; Rectum \_\_\_ irritated, \_\_\_ raw, \_\_\_ painful.

**C. Heart and Blood vessels:** \_\_\_ Difficulty breathing; \_\_\_ Chest pain; \_\_\_ Palpitations or irregular heart beat; \_\_\_ Swelling of legs/feet/hands/eyes.

**D. Neurological and Skeletal:** \_\_\_ Headache (how long \_\_\_\_\_, onset \_\_\_\_\_, regular \_\_\_/periodic \_\_\_/irregular; where does it hurt? \_\_\_\_\_).



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Ringing noises.  Dizziness.  Lightheadedness;  Joint pains (which ones \_\_\_\_\_; how often \_\_\_\_\_)  Muscle pains (where? \_\_\_\_\_).  
 Arthritis (where? \_\_\_\_\_)  Other  
(explain \_\_\_\_\_)

**E. Skin:**  Sores (kind \_\_\_\_\_);  Hives (where? \_\_\_\_\_; how often? \_\_\_\_\_); causes? \_\_\_\_\_  
 Rash (what type? \_\_\_\_\_; where? \_\_\_\_\_; causes? \_\_\_\_\_)

**F. Genitourinary: Urination:**  normal;  problems;  bedwetting;  frequent infections. **Menstruation:**  normal;  irregular;  severe cramping &/or bleeding.

**G. Other**

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THE ANSWERS YOU HAVE PROVIDED WILL HELP DR. MCFADDEN UNDERSTAND YOUR SITUATION AND HELP HER TO DIAGNOSE YOUR MEDICAL PROBLEMS AND RECOMMEND APPROPRIATE TREATMENT FOR THEM WHICH YOU WILL BE ABLE TO FOLLOW.

THANK YOU FOR TAKING THE TIME TO FILL OUT BOTH SIDES OF THIS FORM.

IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK THEM AT ANY TIME.