The ENT Office
OTORHINOLARYNGOLOGY
15 Point Finger Road, Ralmar Upper Level, Paget Bermuda DV04
Phone: 441-261-5337 | FAX: 441-261-5133 | Email: info@entoffice.bm

Patient Name: _____ **DOB:** _____ **Age:** _____

Primary Care Physician: _____ **Referring Physician:** _____

PLEASE ANSWER ALL QUESTIONS

1. What is your reason for today's visit? _____
   _____
2. When did the problem/discomfort start? _____
3. Where is the problem/discomfort located? _____
4. What makes it worse? _____
5. If there are any other symptoms associated with this problem, please describe. _____
   _____
6. Have you been under the care of any other physicians for this problem? _____

GENERAL REVIEW OF SYSTEMS- Are you currently having any of the following symptoms? (Please circle yes or no)

Y	N	Blurred/impaired vision	Y	N	Swollen neck
Y	N	Dry eyes	Y	N	Frequent coughing
Y	N	Hearing loss	Y	N	Sputum productive cough
Y	N	Sore throat	Y	N	Shortness of breath
Y	N	Bleeding gums	Y	N	Asthma or wheezing
Y	N	Voice change	Y	N	Snoring
Y	N	Difficulty swallowing	Y	N	I am currently pregnant

Please list ALL prescription medications that you take:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list ALL over the counter medications and supplements that you take:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list ALL allergies that you have:

_____
_____
_____

Past Medical History: (Check all that apply)

☐ Heart Disease	☐ High Blood Pressure	☐ Emphysema	☐ Diabetes
☐ Heart Valve Problems	☐ Thyroid Disease	☐ Asthma	☐ Cancer
☐ Heart Failure	☐ Liver Disease	☐ COPD	☐ Bleeding Disorder
☐ HIV Disease/Exposure	☐ High Cholesterol	☐ Kidney Disease	☐ Hepatitis (A, B, or C)
☐ Previous Heart Attack	☐ Lung Problems	☐ Stroke	☐ Other: _____

Please provide information about previous surgeries and hospitalizations (include date or year):

Surgeries/Procedures		Hospitalizations	
_____	**Date:** _____	_____	**Date:** _____
_____	**Date:** _____	_____	**Date:** _____
_____	**Date:** _____	_____	**Date:** _____
_____	**Date:** _____	_____	**Date:** _____
_____	**Date:** _____	_____	**Date:** _____

Family History:

Any major illnesses of a blood relative (Mother, Father, Brother, Sister)? Example: Diabetes- Mother

_____ _____
_____ _____

Social History:

Cigarette Smoking	☐ Never	____ Packs Per day	____ Years total	____ Year Quit
Use of Alcohol	◯ Never	◯ Rare/Social	◯ Moderate	◯ Daily
Exercise Level	◯ Never	◯ Rare	◯ Moderate	◯ Daily

Patient /Guardian Signature: _____ **Date:** _____

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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ _____

Parish: _____ Post Code: _____ Sex (Circle One): Male Female

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Preferred Pharmacy: _____

INSURANCE INFORMATION

Insurance Coverage (Circle One): Yes No If no, how do you intend to pay (Circle One): Cash Debit/Credit Card

Insurance Company: _____ Policy/Certificate #: _____

Group #: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy Holder Phone Number: _____

EMERGENCY CONTACT INFORMATION

Name & Relationship to Patient: _____ Phone Number:_____

Name & Relationship to Patient: _____ Phone Number:_____

Patient /Guardian Signature: _____ **Date:** _____

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PATIENT CONFIDENTIALITY FORM

Patient Name: _____

Patient Date of Birth: _____

Guardian's Name: _____

Patient Confidentiality is a top priority at our office. Therefore, it is important that you provide us with the following information to ensure that there is no violation of your privacy.

PLEASE CHECK REFERENCE BELOW

_____ You may discuss my medical information ONLY with me

_____ I give permission to discuss my medical information with the following people:

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at the ENT Office.

Patient /Guardian Signature: _____ **Date:** _____