



Dr. Sanford Dolgin
Dr. Warren Goldstein

Excellence in Specialty Care for the Head and Neck ~ A Division of ENT and Allergy Associates of Florida

PATIENT INFORMATION

Date _____

Last Name _____ First _____ M _____ DOB _____

REASON FOR APPOINTMENT:

Email _____ SSN _____ Gender: Male / Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work # _____ Mobile # _____

Marital Status _____ Language(s) Spoken _____ Race _____

PREFERRED METHOD OF CONTACT (please circle) Home Work Mobile

Employer(s) Name _____ Phone _____ Occupation _____

Guardian Information (If Patient is a minor / Responsible Party):

Last Name _____ First _____ M _____ DOB _____

Relationship to patient _____

Emergency Contact Name _____ Relationship _____ Phone _____

How did you hear about us (please circle)? Google – Yahoo – Internet - Yellow Pages – Family/Friend
A Physician _____ Other: _____

REFERRING PHYSICIAN: Name _____ City _____ State _____

Phone _____ Fax _____

PCP/PRIMARY CARE PHYSICIAN: Name _____ City _____ State _____

Phone _____ Fax _____

LOCAL PHARMACY Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Brooksville

11373 Cortez Blvd, Suite 408
(Hernando Medical office – Building C)
Brooksville, FL 34613
Phone: 352-688-0800
Fax: 352-462-3277

Trinity

1818 Short Branch Drive
Suite 103
Trinity, FL 34655
Phone: 352-593-3277
Fax: 352-462-3277

Excellence in Specialty Care for the Head and Neck ~ A Division of ENT and Allergy Associates of Florida

PAST MEDICAL HISTORY: Please indicate if you have/had a history of the following SEE ATTACHED LIST

_____ Arthritis	_____ HBP	_____ Reflux (GERD)
_____ Asthma	_____ Hepatitis	_____ Treatment for Alcoholism
_____ Anxiety	_____ Heart Disease	_____ Treatment for Substance Abuse
_____ Bleeding disorder	_____ Heart Stent	_____ Thyroid Disease
_____ Diabetes	_____ HIV	_____ TIA
_____ Emphysema	_____ Stroke	_____ Cancer: _____

SURGICAL / HOSPITALIZATION HISTORY: SEE ATTACHED LIST

Surgery	YEAR

ENT History: Please indicate if you are currently having problems with any of the following:

<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Snoring	<input type="checkbox"/> Sinus	
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Hearing loss	
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Ear drainage		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Nasal Drainage	<input type="checkbox"/> Throat pain		

ENT Surgical History: Check all that apply

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Sinus Surgery
<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Nasal Surgery
<input type="checkbox"/> Thyroidectomy	<input type="checkbox"/> Ear Tubes
<input type="checkbox"/> Ear Surgery	<input type="checkbox"/> Other: _____

PATIENT NAME: _____ **HEIGHT:** _____ **WEIGHT:** _____

DRUG ALLERGIES: _____ **OTHER ALLERGIES:** _____

Brooksville

11373 Cortez Blvd, Suite 408
(Hernando Medical office – Building C)
Brooksville, FL 34613
Phone: 352-688-0800
Fax: 352-462-3277

Trinity

1818 Short Branch Drive
Suite 103
Trinity, FL 34655
Phone: 352-593-3277
Fax: 352-462-3277

Excellence in Specialty Care for the Head and Neck ~ A Division of ENT and Allergy Associates of Florida

MEDICATION LIST SEE ATTACHED LIST

Please list ALL medications (include over the counter drugs) you are taking now, include dosage & frequency

Medication	Dosage	Frequency	Medication	Dosage	Frequency

SOCIAL HISTORY

What is your occupation?
Are you retired? <u>Yes / No</u> What was your occupation?
Do you drink caffeine or use caffeine stimulants? <u>Yes / No</u> How many servings per day?
Do you smoke? <u>Yes/No</u> If yes, how much per day?
Did you ever smoke? <u>Yes/No</u> If yes, how long and when did you quit?
Do you drink alcohol? <u>Yes / No</u> How much?
Do you use recreational drugs? <u>Yes / No</u>
How much water do you drink?

FAMILY HISTORY

Family Members:	Father	Mother	Siblings	Children
	Alive: <input type="checkbox"/> Yes <input type="checkbox"/> No	Alive: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Mental Illness				
Migraine				
Stroke				
Thyroid				

I certify that I have disclosed all of my medical history known to me. I acknowledge that I am responsible to make your office aware of any changes to my medical health.

Signature: _____ Date: _____

Brooksville

11373 Cortez Blvd, Suite 408
(Hernando Medical office – Building C)
Brooksville, FL 34613
Phone: 352-688-0800
Fax: 352-462-3277

Trinity

1818 Short Branch Drive
Suite 103
Trinity, FL 34655
Phone: 352-593-3277
Fax: 352-462-3277