Mid-Michigan ENT | ALIGN ENT+ Allergy Partner

Patient Registration

Last Name _____ First Name _____ MI _____

DOB _____ Sex _____ Occupation _____

What is the reason for today's visit? _____

Pharmacy Name _____ Address _____

Medical History—Please check if you have or have had any of the following conditions

- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clotting
- ☐ Cancer (list)_____
- ☐ Carotid Artery Stenosis/Disease
- ☐ Chronic Ear Infections
- ☐ Chronic Sinusitis
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ COVID-19 Virus Infection
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Gastroesophageal Reflux Disease/Heartburn
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Heart Murmur/Heart Valve Insufficiency
- ☐ Hypertension/High blood pressure
- ☐ Injuries to (list)
  - Nose_____
  - Face_____
  - Head_____
- ☐ Kidney Problems (list)_____
- ☐ Peripheral Vascular Disease
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
- ☐ Stomach Ulcer or Duodenal Ulcer
- ☐ Stroke/CVA
- ☐ Thyroid Disease
- ☐ Thyroid Nodule
- ☐ Tinnitus
- ☐ Vitamin D Deficiency
- ☐ Methicillian Resistant Staphylococcus Aureus Infection (MRSA)

Are you at risk for falling? ☐No ☐Yes

Hospitalizations (Date & reason- NOT surgeries) _____

_____

☐ Latex Allergy ☐ Iodine/IVP Dye Allergy (note reaction) _____

List DRUG allergies and reactions or check ☐ No Known Drug Allergies

_____

_____

_____

FOOD allergies and reactions _____

_____

_____

List ALL Medications , Doses, and Frequency (include prescriptions, over-the-counter, and supplements) or check ☐ No Current Medications. *If you have a list, please provide with this form and we can copy it for you.*

_____

_____

_____

_____

Surgical History—Please check all that apply or check ☐ No Surgeries

☐ Adenoidectomy
☐ Angioplasty
☐ Cardiac Pacemaker
☐ Cardiac Stent
☐ Defibrillator Implant
☐ Ear Surgery
☐ Endarterectomy
☐ Other

☐ Hysterectomy
☐ Mastoidectomy
☐ Parathyroidectomy
☐ Rhinoplasty
☐ Sinus Surgery
☐ Spinal Fusion – Neck
Thyroidectomy
☐ L ☐ R ☐ Subtotal ☐ Total

☐ Tonsillectomy
☐ Total Hip Replacement
☐ Total Knee Replacement
☐ Tracheostomy
☐ Tympanostomy (with Tube Placement)
☐ Valve Replacement

Social History—Please check all that apply

Tobacco Use (ages 13+) ☐ Never ☐ Former Smoker: Years_____Quit Date_____
☐ Current Smoker: Type_____Quantity_____
Alcohol Use ☐ Yes ☐ No If yes, quantity _____
Illicit or Recreational Drugs ☐ Yes ☐ No If yes, specify _____

Family History—Please check all that apply

☐ No relevant family history ☐ Unknown family history ☐ Anesthesia Complications ☐ Asthma
☐ Bleeding Disorder ☐ Congenital Hearing loss/Childhood Hearing Loss
☐ Cancer (list type)_____

Diagnostic Studies—Please check all that apply

Please bring relevant test results and CD images to your appointment, if possible

☐ ABR
☐ Allergy Testing
☐ Cardiovascular Stress Test
☐ Coronary Angiogram
☐ EGD
☐ Pulmonary Function Test
☐ Sleep Study
☐ Swallow Study
☐ Thyroid Problems

Relevant Imaging details: note what and where
☐ CT Scan _____
☐ MRI _____
☐ Ultrasound_____
☐ X-Ray_____

Females: Are you currently or possibly pregnant? ☐ Yes ☐ No Currently breastfeeding? ☐ Yes ☐ No

For Children Only (ages 12 and under)

Any Newborn/Birth Complications? ☐ Yes ☐ No If yes, explain_____
Any Pregnancy Complications? ☐ Yes ☐ No If yes, explain_____
Newborn Hearing Screen? ☐ Yes ☐ No If yes, ☐ Pass ☐ Fail
Smoke Exposure ☐ None ☐ Minimal ☐ Frequent ☐ Daily
☐ Family members smoke indoors ☐ Family members smoke outdoors only
☐ Caregiver smokes indoors ☐ Caregiver smokes outdoors only

Please return this form when finished.
You will be called back for your appointment once this is returned.