



RICHARD G. LEE, MD

EAR · NOSE · THROAT

INTAKE FORM

Patient Name: _____ Date of Birth _____

Why are we seeing you today? _____

MEDICAL HISTORY— Please circle all conditions that apply to the patient:

- | | |
|--|-----------------------------|
| Allergic Rhinitis (allergic reaction in nose/eyes) | Anemia |
| Anxiety | Arthritis |
| Asthma | Atrial Fibrillation |
| Chest Pain | Circulatory System Disorder |
| Congestive Heart Failure | Depression |
| Diabetes | Emphysema |
| Gout | Headache |
| Hearing Loss | Heart Attack |
| Heartburn | Herniated Disc |
| High Blood Pressure (hypertension) | High Cholesterol |
| High Lipids | Hypothyroid |
| Insomnia | Irritable Bowel Syndrome |
| Kidney Failure | Migraine |
| Mitral Valve Disorder | Osteoporosis |
| Sinusitis | Skin Disorder |
| Stroke | Visual Impairment |
| Other: _____ | |

Do you have any family history of the above medical conditions? If yes, please list relationship(s) and condition(s): _____

Immunizations up to date? Yes No

Please list previous surgeries and the dates: _____

Do you use tobacco (or are exposed)?	Yes	No	If yes, how much?	_____
Alcohol?	Yes	No	If yes, how much?	_____
Illicit Drugs?	Yes	No	If yes, how much?	_____

Drug allergies (please list reaction)? _____

Medications (list dosage & schedule): _____

Have you ever tested positive for MRSA? Yes No