Polaris Medical Group - ENT, LLC

Lisa Perry-Gilkes, M.D.

3885 Princeton Lakes Way Suite 312a Atlanta GA 30331 phone 404.766.8110

Patient Information				
Name (Last, First M.I.):				Date: / /
Marital Status:	Salutation: Mr.| Mrs.| Ms.| Miss	Sex:	Age:	Date of Birth: / /
Is this your legal name? ☐Yes ☐No		If not what is your legal name?		Social Security #: - -
Mailing address:			E–mail:	
City:		State:	Zip Code:	Home Phone #: ( ) -
Occupation:		Employer:		Employer Phone #: ( ) -
Employer mailing address:		City:	State:	Zip Code:

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino Preferred Language:

Insurance Information (Please give your insurance card and photo ID to the front office)			
Person responsible for bill:			Date of Birth: / /
Is this person a patient here? ☐Yes ☐No			
Mailing address (if different):			P.O. box:
City:	State:	Zip Code:	Home Phone #: ( ) -
Occupation:	Employer:		Employer Phone #: ( ) -
Employer mailing address:	City:	State:	Zip Code:

Please indicate primary insurance

☐Aetna ☐ Blue cross ☐ Cigna ☐ Coventry ☐ Humana

☐Medicaid ☐ Medicare ☐ Other ☐ Tricare ☐ United Healthcare

Subscriber's name:		Social Security #: - -	Date of Birth: / /
Group no.:	Policy no.:		Co-payment: $

Patient's relation to subscriber:

☐Self ☐ Spouse ☐ Child ☐ Other

Subscriber's name:		
Group no.:	Policy no.:	Co-payment: $

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Chief Complaint/History of Illness

1. What is the reason for today's visit?
2. How long have you had this problem? (if applicable)
3. How severe is this problem?
4. Where is this problem located?
5. How often does this problem occur? When did it start?
6. What makes it better?
7. What makes it worse?
8. What other symptoms are you having?
9. Have you sought legal advice regarding this problem?
10. Is this problem occupational related?
11. Have you been treated for this problem before?
12. Does anything else bother you?

Do you currently have?

- ☐ Fevers
- ☐ Hemorrhoids
- ☐ Chest Pain
- ☐ Back Pain
- ☐ Headaches
- ☐ Trouble Breathing
- ☐ Blurred Vision
- ☐ Skin Rashes
- ☐ Depression
- ☐ Nosebleeds
- ☐ Weight Change
- ☐ Appetite Changes
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Allergies

Other?

_____

_____

_____

_____

_____

_____

Past Medical History

Please check any illness you have had?

- ☐ High blood pressure
- ☐ Neurologic problems
- ☐ Kidney diease
- ☐ Diabetes
- ☐ Neck/Back disease
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Chronic headaches
- ☐ Stroke/ mini-stroke
- ☐ Heart problems
- ☐ Angina
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Rheumatic fever
- ☐ Migraines
- ☐ Sinusitis
- ☐ Peptic ulcers/GERD
- ☐ Thyroid disease
- ☐ HIV
- ☐ Arthritis
- ☐ Lung disease

Allergic Reaction/Cancer/Other (please list type and date diagnosed)

_____

Past Surgical History

Please list/explain surgeries you've had or reasons for past hospitalization

_____

_____

_____

_____

_____

Please describe any complicaions you've had related to surgery

_____

_____

_____

Describe any complications you had related to anesthesia

_____

_____

_____

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Social History

1. Occupation/School:

2. How many children do you have?

3. Please list any street drugs you currently use:

4. Do you have any drug addictions?

5. Do you currently smoke or have you in the past?

If Yes to Question 5

☐Cigarettes/Cigar ☐Pipe ☐Dip snuff

Number of years?_____

Cigarette packs per day?_____

Cigar number per day?_____

Pipe number per day? _____

Chew amount per day?_____

Year quit (if applicable):_____

6. Do you drink alcohol? If so, what and how frequently?

7. Do you consume caffeine (tea, coffee, soda)? How often?

8. Describe how much exercise you complete:

Medicine and Allergies

Are you taking any medicines?

☐Yes ☐No

If yes please list them and the dosage?

Medication	Dosage
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Do you take Aspirin or Ibuprofen?

☐Yes ☐No

Do you use eyedrops?

☐Yes ☐No

Do you use nose spray?

☐Yes ☐No

Do you take Warfarin (Coumadin)/Plavix?

☐Yes ☐No

Do you have any allergies?

☐Yes ☐No

Medication allergies (please list):

_____

Food allergies (please list):

_____

Plant/Dust/Mold/Pet allergies (please list):

_____

Family History

Check all illnesses that run in your family:

☐High blood pressure	☐Hearing loss	☐Sickle cell anemia
☐Allergies	☐Alcoholism	☐Psychiatric illness
☐Bleeding problems	☐Thyroid disease	☐Heart attack
☐Cancer	☐Diabetes	☐Poor cicrulation
☐Lung disease	☐Stroke	☐Migraines

Other or anesthesia reactions?

_____

_____

_____

_____

Extra Information?

Please use this space to communicate any other medical information that wasn't listed elsewhere

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Review of Systems (check all symptoms you have had either now or in the past)

Constitutional

☐ Weight loss ☐ Fever ☐ Chills

Eyes

☐ Double vision ☐ Loss of vision ☐ Eye pain

ENT

☐ Hearing loss ☐ Ringing in ears ☐ Dizziness ☐ Ear pain ☐ Ear drainage

☐ Nose drainage ☐ Nasal congestion ☐ Facial Pain ☐ Headaches ☐ Sore mouth/throat

☐ Voice change ☐ Snoring ☐ Hoarseness ☐ Poor sleep ☐ Nosebleeds

☐ Loss of smell ☐ Bleeding gums ☐ Sleep apnea ☐ Difficulty swallowing ☐ Painful swallowing

Cardiovascular/Pulmonary

☐ Chest pain (with rest or activity) ☐ Heart attack ☐ Irregular heartbeat ☐ Poor circulation ☐ Leg pain (during walking)

☐ Coughing up blood ☐ Mitral valve problem ☐ Shortness of breath ☐ Asthma ☐ Pneumonia

☐ Chronic wheezing

Gastrointestinal

☐ Stomach Ulcers ☐ Nausea/Vomiting ☐ Diarrhea ☐ Blood in stool ☐ Jaundice

☐ Abdominal pain ☐ Hernia

Genitourinary

☐ Blood in urine ☐ Painful urination ☐ Urinary incontinence ☐ Difficulty making urine

Musculoskeletal

☐ Neck/Spine surgery ☐ Neck/Back disorder ☐ Arthritis

Neurological

☐ Stroke ☐ Loss of sensation ☐ Mini-stroke ☐ Paralysis of arm/leg ☐ Facial paralysis

☐ Frequent headaches ☐ Temporary loss of vision or speech control

Skin

☐ Skin cancer ☐ Allergy to medical tape, iodine, or latex

Infectious Disease

☐ Hepatitis ☐ HIV/AIDS ☐ Mononucleosis ☐ TB

Psychiatric

☐ Clinical depression ☐ Schizophrenia ☐ Anxiety ☐ Hallucinations ☐ Panic attacks

Do you have any implantable devices? If so, what and where?

Thank you for your cooperation!