MASSACHUSETTS EYE AND EAR

PATIENT INFORMATION

NAME:				DOB:		AGE:	SEX:		
HOME ADDRESS:				CITY:		STATE:	ZIP:		
PRIMARY PHONE:	H	W	C	SECONDARY PHONE:			H	W	C
EMAIL ADDRESS:									
MARITAL STATUS:	S	M	D	W	OCCUPATION:		EMPLOYER:		
EMERGENCY CONTACT #1:				PHONE:		RELATIONSHIP:			
REFERRING DOCTOR:		ADDRESS:				PHONE:	FAX:		
PRIMARY CARE PHYSICIAN:		ADDRESS:				PHONE:	FAX:		
PHARMACY:		ADDRESS:				PHONE:	FAX:		

INSURANCE INFORMATION

PRIMARY INSURANCE:		I.D./POLICY #		GROUP #:	
SUBSCRIBER NAME:		DOB:	PATIENT'S RELATIONSHIP TO SUBSCRIBER:		
			SELF	SPOUSE	CHILD	OTHER
EMPLOYER:	ADDRESS:		PHONE:		
SECONDARY INSURANCE:		I.D./POLICY #		GROUP #:	
SUBSCRIBER NAME:		DOB:	PATIENT'S RELATIONSHIP TO SUBSCRIBER:		
			SELF	SPOUSE	CHILD	OTHER
EMPLOYER:	ADDRESS:		PHONE:		

MASS EYE AND EAR, Emerson Place
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MASSACHUSETTS EYE AND EAR

MEDICATIONS

DRUG NAME	DOSE	INSTRUCTIONS

How many courses of antibiotics have you been on in the past year?	0	1-2	3-4	5+
Have you taken nasal steroid sprays?	YES	NO	FOR HOW LONG? _____	

ALLERGIES

ALLERGY	REACTION

MEDICAL HISTORY

	DATE	HOSPITALIZATIONS & MAJOR ILLNESSES
HOSPITALIZATIONS & MAJOR ILLNESSES		

	DATE	SURGERY
SURGERIES		

	Y	N		Y	N	
HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?			ASTHMA			HIGH BLOOD PRESSURE
			ABNORMAL BLEEDING			NERVOUS DISORDER
			HEART DISEASE			TUBERCULOSIS
DO YOU HAVE:			DIABETES			PACEMAKER

SMOKING		NEVER SMOKED	SMOKERS/FORMER SMOKERS	
		SMOKE SOME DAYS		YEARS SMOKED
		SMOKE EVERY DAY		PACKS PER DAY
		FORMER SMOKER	_____	QUIT DATE
SMOKELESS TOBACCO		NEVER USED		FORMER USER
		CURRENT USER	_____	QUIT DATE

	Y	N		Y	N	
FAMILY HISTORY M (Mother) F (Father) S (Sister) B (Brother) O (Other Relative)			ABNORMAL BLEEDING			HEARING LOSS
			CANCER			HEART DISEASE
			DIABETES			STROKE

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