Welcome to North Country Otolaryngology & Audiology

_____has a scheduled appointment with _____

On _____at _____: _____am/pm

Please review this information to be ready for your appointment

We are located at 1080 Hospital Drive Suite #5, St. Johnsbury, VT 05819 in the Richard H. Bloch Building on the NVRH Campus. Exit 22 off of I-91.

"This practice is a joint collaboration between Northeastern Vermont Regional Hospital (NVRH) and Littleton Regional Healthcare (LRH). Patients have the potential to be seen in either location, so we ask that you please fill out the enclosed forms and bring them with you."

Instructions

1. Arrive 15 minutes early to check in
2. Fill out the enclosed required paperwork
3. Bring your insurance cards and present them upon check-in
4. Copayments and self-insured (self-pay) visit payments are expected to be paid at the time of service

Cancellations: If an appointment cannot be kept, please contact the office to cancel your appointment as soon as possible. This will allow us to schedule other patients who require our care.

Reschedule: If the date and time of your current appointment is no longer convenient, please call our office directly to be rescheduled.

Providing our office with the requested documentation completed at check-in will allow us to provide accurate, efficient and confidential, service upon your arrival to our office.
We appreciate your help with this.

If you have any questions please call 802 748-5126 or visit our website at www.nvrh.org/ear-nose-throat-otolaryngology

Thank you

North Country Otolaryngology & Audiology
Deane E. Rankin M.D
Patrick M. Fitzpatrick D.O
Danny Ballentine PA
1080 Hospital Drive Suite 5, St Johnsbury, VT 05819

Today's Date _____

Last Name	**First Name**	**Middle Initial**	**Age**	**DOB**

Occupation	**Please circle:** Male / Female	**Email Address**

Current Primary Physician	**Current Pharmacy/Town**	**Referring Physician**

Chief Complaint: What symptoms are you having that bring you this visit?

_____

Medications: List below the medications you are taking. Include prescriptions, and all other medicines or supplements. **(Please attached your medication list if greater than 3 items.)**

Name Amount How often

_____

_____

_____

Allergies: Are you allergic to any medications? **Yes** **No**
If so, which ones? _____

_____

Past Medical History:

Have you had any serious injury? Yes No _____
If yes, please explain

Have you ever had any ear surgery? Yes No _____
If yes, what type and when?

Have you ever had any other type of surgery? Yes No _____
If yes, what type and when?

Do you have any major illnesses? Yes No _____
Please explain:

Family History: What medical problems run in your family?

Father: _____
Mother: _____
Other: _____

Social History:

Do you smoke? Yes No How many cigarettes per day? _____ How long? _____
Did you smoke? Yes No How long? _____ Quit date? _____
Do you drink alcohol? Yes No How many drinks per day? _____ How long? _____

Have you had problems with alcoholism? Yes No
Have you had problems with drug use? Yes No
Do you drink caffeine? Yes No

Physician Notes:

History of present illness: **PLEASE ANSWER EACH OF THE FOLLOWING**

Describe the details of your present problem.

	Right Ear	**Left Ear**	**Duration**	**N/A**
Hearing Loss	_____	_____	_____	_____
Fluctuating Hearing	_____	_____	_____	_____
Ear Fullness	_____	_____	_____	_____
Ringing/Tinnitus	_____	_____	_____	_____
Ear Infection	_____	_____	_____	_____
Ear Drainage	_____	_____	_____	_____
Better Hearing Ear	_____	_____	_____	_____
Hearing Aid	_____	_____	_____	_____
Ear Pain	_____	_____	_____	_____
Facial Weakness	_____	_____	_____	_____
Facial Spasms	_____	_____	_____	_____
Noise Exposure	_____	_____	_____	_____

Location: Work, Home, Recreational Noise Protection? Yes No

Do you have dizziness? Yes No

When did it begin? _____ How long does it last? _____
How often does it happen? _____ Is your dizziness: Mild_____ Moderate_____Severe_____
Does your dizziness affect your work? **Yes/No** Does your dizziness effect your driving? **Yes/No**

Describe your dizziness:

Spinning/Vertigo Yes No Positional Yes No
Lightheadedness Yes No Nausea Yes No
Off Balance Yes No Headache Yes No

Do you have problems with:			If yes, please explain?
Numbness on the face	Yes	No	_____
Double Vision	Yes	No	_____
Blurred Vision	Yes	No	_____
Difficult Swallowing	Yes	No	_____
Hoarseness	Yes	No	_____
Tongue Weakness	Yes	No	_____
Shoulder Weakness	Yes	No	_____

Review of Systems:

Have you ever been treated for any of the following illnesses? **Please check all that apply.**

Fatigue	_____	Ulcer	_____	Thyroid Problems	_____
Fever	_____	Blood in Stool	_____	Pituitary Problems	_____
Weight Loss	_____	Colitis	_____	Bleeding Disorder	_____
Snoring	_____	Prostate Problems	_____	Anemia	_____
Hoarseness	_____	Kidney Stones	_____	Lymphoma	_____
Glaucoma	_____	Hepatitis	_____	Venereal disease	_____
Double Vision	_____	Liver trouble	_____	AIDS/HIV	_____
Other eye problems	_____	Gall bladder problems	_____	Cancer	_____
Loss of taste	_____	Kidney infection	_____	Blood transfusion	_____
Loss of smell	_____	Blood in urine	_____	Seizures	_____
Sinus trouble	_____	Bladder infection	_____	Loss of consciousness	_____
Difficulty swallowing	_____	Arthritis	_____	Head injury/concussion	_____
High Blood Pressure	_____	Fibromyalgia	_____	Multiple sclerosis	_____
Heart Failure	_____	Bone disease	_____	Nervous Disorder	_____
Chest pain/Angina	_____	Joint disease	_____	Anxiety	_____
Heart Attack	_____	Back problems	_____	Depression	_____
Ankle/Foot swelling	_____	Breast (lump/tumor)	_____	Frequent infections	_____
Shortness of breath	_____	Rashes	_____	Environmental allergies	_____
High cholesterol	_____	Eczema	_____	Hay fever	_____
Cough	_____	Headaches	_____	Reflux	_____
Diabetes	_____	Meningitis	_____	Sleep apnea	_____

Please add details:

_____

_____

I acknowledge that the information stated above is true and complete:

_____ _____

Patient/Guardian Signature Date

_____ _____

Reviewing Physician Signature Date