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 ____________________________

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Age</th>
<th>DOB</th>
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</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Please circle: Male / Female</th>
<th>Email Address</th>
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</table>

<table>
<thead>
<tr>
<th>Current Primary Physician</th>
<th>Current Pharmacy/Town</th>
<th>Referring Physician</th>
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</table>

**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.*)  

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
<th>How often</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Right Ear</th>
<th>Left Ear</th>
<th>Duration</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Loss</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Fluctuating Hearing</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Ear Fullness</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Ringing/Tinnitus</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Ear Infection</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Ear Drainage</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Better Hearing Ear</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Ear Pain</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Facial Weakness</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
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<tr>
<td>Facial Spasms</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
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<tr>
<td>Noise Exposure</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Location: Work, Home, Recreational</td>
<td>Noise Protection?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Positional</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinning/Vertigo</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lightheadedness</td>
<td>Yes</td>
<td>No</td>
<td>Nausea</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Off Balance</td>
<td>Yes</td>
<td>No</td>
<td>Headache</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
**Do you have problems with:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness on the face</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Double Vision</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blurred Vision</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficult Swallowing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hoarseness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tongue Weakness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Shoulder Weakness</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes, please explain?

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**Review of Systems:**

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

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

Please add details:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

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

Patient/Guardian Signature ___________________________ Date ___________________________

Reviewing Physician Signature _________________________ Date ___________________________