

OAKDALE EAR NOSE & THROAT CLINIC, P.A.
(763) 520-7840

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with written consent.

Last Name: _____ First Name: _____ Initial: _____ Date of Birth: _____

Why are we seeing you today? _____

How long have you had this problem? _____

Please check the appropriate box:

YES	NO	Problems	YES	NO	Problems
		Vision			Kidney Stones
		Hearing Loss			Arthritis
		Runny Nose			Psychiatric
		Sore Throat			Thyroid
		Seasonal Allergies			Diabetes
		Chest Pain			Heart
		Asthma			Cancer
		Bronchitis			Skin Lesions
		Reflux			Blood in Stools
		Immunizations up to date			

Do you have any other problems not listed above? None

Please list:

Family Medical History:

Mother:

Father:

List names and dates of all operations you have had. None

Medication: Please list all drugs you take None

Drug Name: _____ Drug Name: _____

Height: _____ Weight: _____

Females Only: Are you Pregnant? Yes No # of pregnancies _____

Tobacco Use: None How many packs/day? _____ # of years _____ = packs/year _____

Do you consume alcohol? No Yes Amount / day _____ # of years _____

The above information is true and accurate. (parent / guardian, if patient is a minor)

Patient Signature: _____

Date: _____

DO NOT WRITE - OFFICE USE ONLY

ALLERGIES

DOCTOR'S USE ONLY

Dr. Signature/Initial Date Vital Signs

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

USE BACK SIDE OF SHEET IF NECESSARY

OAKDALE EAR, NOSE & THROAT, PA
3366 OAKDALE AVE NORTH #150
ROBBINSDALE, MINNESOTA 55422
763-520-7840

PATIENT NAME: _____ DATE _____

IF REFERRED BY A DOCTOR OR CLINIC, PLEASE GIVE US THE DOCTOR'S NAME.

FULL NAME _____

CLINIC NAME OR
ADDRESS _____

PLEASE STATE YOUR FAMILY DOCTOR'S NAME IF NOT REFERRED:

FULL NAME: _____

CLINIC OR ADDRESS _____

IF NO FAMILY DOCTOR, PLEASE CHECK HERE _____

PREFERRED PHARMACY: _____

PHARMACY PHONE NUMBER: _____

PHARMACY ADDRESS: _____
