LIFEBRIDGE HEALTH
CARE BRAVELY

LBH ENT New Patient Intake Form

Personal Information

Name _____ DOB_____

Address_____ Phone #_____

Email_____

Emergency Contact Name _____ Phone # _____

Referring Provider _____

Primary Care Provider_____

Reason for Visit _____

Allergies:

☐ No Known Drug Allergies

☐ Outdoor Allergies _____

☐ Indoor Allergies_____

☐ Food Allergies _____

☐ Medication Allergies_____

Smoking Status:

☐ Never Smoker ☐ Former Smoker ☐ Current Smoker

Current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

LIFEBRIDGE HEALTH
CARE BRAVELY

LBH ENT New Patient Intake Form

Medical History/ Conditions- Current or treated in the past. (Check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Blood in Stool
- ☐ Blood in Urine
- ☐ Cancer (Specify Below)
- ☐ Change in Bowel Habits
- ☐ Chest Pain
- ☐ Chronic Headaches
- ☐ Constipation
- ☐ COPD/Breathing Problems
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Difficulty Urinating
- ☐ Emphysema
- ☐ Facial Pain
- ☐ Fever
- ☐ Frequent Urination
- ☐ General Allergies
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Palpitations
- ☐ Heartburn/ Gastric Reflux
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS Positive
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Loss of Appetite
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Muscle Weakness
- ☐ Nasal Congestion
- ☐ Nausea/Vomiting
- ☐ Numbness
- ☐ Post Nasal Drip
- ☐ Mucous in Nose/Throat
- ☐ Production of Sputum
- ☐ Recurrent Sinusitis
- ☐ Recurrent Urinary Tract Infections
- ☐ Runny Nose
- ☐ Seizures Disorder or Epilepsy
- ☐ Skin Rash
- ☐ Sleep Apnea
- ☐ Spitting Blood
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tinnitus/ Ear Ringing
- ☐ Vertigo/ Dizziness
- ☐ Weakness of the Extremities
- ☐ Weight Loss
- ☐ Wheals
- ☐ Wheezing
- ☐ None

Surgical History (Indicate all that apply)

_____ **Date of Surgery**_____

_____ **Date of Surgery**_____

_____ **Date of Surgery**_____

_____ **Date of Surgery**_____

_____ **Date of Surgery**_____