Gulfcoast
Ear, Nose & Throat
Associates

New Patient Intake

PLEASE PRINT: Patient Name (List full name as it is on your insurance card):

First Name: ______________________ **Last Name:** ________________________

Date of Birth: ___________

Allergies to Medications:

Surgeries:	**Date(Mo/Yr)**	**Complications**

Social History:

Alcohol Use: **Yes** **No** amount drinks per week ______ beer/wine/liquor

Current Smoker: **Yes** **No** packs per day: ____for ____ years

OR Former smoker quit: ___________

Medications: Please print clearly with times per day and dosages: You can list on back if needed or provide us a list.

Medical History Please check all that apply.

Condition	Myself	Other Immediate Family
Allergic rhinitis		
Anemia		
Anxiety		
Arthritis		
Asthma		
Atrial Fibrillation		
Chest Pain		
Circulatory System Disorder		
Congestive Heart Failure		
Depression		
Diabetes		
Emphysema		
Gout		
Headache		
Hearing Loss		
Heart Attack		
Heartburn		
Herniated Disk		
High Blood Pressure		
High Cholesterol		
High Lipids		
Hypothyroid		
Insomnia		
Irritable Bowel Syndrome		
Kidney Failure		
Migraine		
Mitral Valve Disorder		
Osteoporosis		
Sinusitis		
Skin Disorder		
Stroke		
Visual Impairment		

If none of the above apply, please check here: ____________