EarNoseThroat
AllergySnoring
C E N T E R

PREMIER SINUS
AND ALLERGY

Franklin M. Douglis, M.D.
Board Certified Otolaryngology, Sleep Medicine and Obesity Medicine

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Board Certified Otolaryngology

Welcome!,

Thank you for the confidence and trust that you have placed in us. We look forward to participating in your healthcare needs.

Please print and complete the attached forms. You will need to arrive 30 minutes prior to your scheduled appointment. Bring the completed forms along with a copy of your Insurance Card and Driver's License to your scheduled appointment. These steps will help streamline your check-in process at your scheduled appointment.

We have provided the address of our two locations :

- Conroe Office: 3000 W. Davis St. Conroe, TX 77304
- Spring Office: 6611 FM 2920 Spring, TX 77379

If you have any questions or concerns, please call the office at 936-539-9322 or 281-376-1188.

The fax number for both locations is: 936-539-9104

We look forward to seeing you at your appointment!

Franklin Douglis / Shawn Allen and Staff

BASIC MEDICAL HISTORY

NAME:
LAST_____**FIRST**_____**MI** _____**TODAY'S DATE**_____

AGE_____**DATE OF BIRTH**_____**DATE OF LAST PHYSICAL**_____**SEX:** MALE / FEMALE

WHAT IS YOUR REASON FOR THIS VISIT?_____

_____

YOU WERE REFERRED BY?_____

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING: INCLUDE PRESCRIBED, OVER THE COUNTER AND VITAMIN & NUTRITIONAL SUPPLEMENTS

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

If More Space is Needed, please turn page over and list on back.....Check Box for medication listed on back ☐

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? Darken in the bubble (O) for YES.

O Breast Cancer	O Heart Attack	O Stomach Ulcer	O Panic Attacks
O Lung Cancer	O High Blood Pressure	O Hemorrhoids	O Anorexia
O Skin Cancer	O Low Blood Pressure	O Crohn's Disease	O Bulimia
O Throat Cancer	O Varicose Veins	O Are you Pregnant?	O Multiple Sclerosis
O Prostate Cancer	O Heart Disease	O Prostate Enlargement	O Migraine Headache
O Other Cancer (specify)	O Pace Maker	O Renal Failure	O Hypo Thyroid
O Lymphoma	O Other implanted device	O Kidney Disease	O Hyper Thyroid
O Diabetes	O Asthma	O Liver Disease	O Anemia
O Glaucoma	O Chronic Bronchitis	O Breast lump(s)	O Hemophilia
O Meniere's Disease	O Emphysema	O Sexually Transmitted Disease	O HIV
O Nasal Allergies	O Tuberculosis		O Other
O Sleep Apnea	O Pneumonia	O Venereal Disease	Describe:
O Blood Clots / DVT	O Gastrointestinal Reflux	O Anxiety	
O High Cholesterol	O Hepatitis	O Depression	

ARE YOU ALLERGIC TO ANY MEDICATION? _____YES_____NO. IF YES, PLEASE LIST BELOW:

NAME OF MEDICATION	TYPE OF REACTION

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? Darken in the bubble (O) for YES.

Adhesive tape O Iodine O Latex O Metal O Seafood O Contrast Dye O

NAME_____

BASIC MEDICAL HISTORY CONTINUED

PAST SURGERIES AND HOSPITALIZATIONS:

List any surgeries: Date:

_____

_____

_____

_____

_____

Have you ever had any problems with anesthesia (being numbed or put to sleep)? YES / NO. If yes, please list types of problems:

_____

Have you ever been hospitalized for non-surgical reason? YES / NO. If yes, please list reasons for hospitalizations:

_____

_____

MARK FAMILY MEMBERS WHO BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? Darken in the bubble (O) for YES.

PROBLEM:	Mother	Father	Brother	Sister	PROBLEM:	Mother	Father	Brother	Sister
Anesthesia problems	O	O	O	O	Heart Disease	O	O	O	O
Thyroid Cancer	O	O	O	O	High Blood Pressure	O	O	O	O
Lung Cancer	O	O	O	O	Asthma	O	O	O	O
Unspecified Cancer	O	O	O	O	Stroke	O	O	O	O
Hearing Loss before age 20	O	O	O	O	Diabetes	O	O	O	O
Hearing Loss after age 20	O	O	O	O	Bleeding / Clotting problem	O	O	O	O

COMPLETE THE FOLLOWING: Darken in the bubble (O) for all that apply

Tobacco Use	O YES O NO	O In the Past O Current	O Started:	O Cigarettes O Vapor Cigs. O Cigars	O Smokeless tobacco
Give the closest **amount of cigarettes/vapor cigarettes** you smoke in a day	O 5 or less per day	O 6-10 per day	O 11-20 per day	O 21-30 per day	O 31 or more per day
Alcoholic Beverages: *Have or do you use alcohol beverages*	O YES O NO	Did you use alcohol beverages in the last year	O YES O NO	How often? O Never	O 2-4 month O 2-3 week O 4+ week
Do you use drugs Recreationally?	O YES O NO				
Caffeine Use: (coffee, tea, chocolate, cola, other caffeinated drinks)	O None	O 1-2 per day	O 2-3 per day	O 4+ per day	
e you exposed to **Second hand Smoke**?	O YES O NO				
Will you accept **transfusion of blood** products if necessary?	O YES O NO				
Home Living Situation:	O Alone / Single		O With Spouse		O Significant Other

NAME_____

BASIC MEDICAL HISTORY CONTINUED

DO YOU HAVE OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING? Darken in the bubble (O) for YES

O Fever	O Masses (lumps) in neck	O Headache	O Itchy eyes
O Chills	O Masses (lumps) in armpit	O Shortness of breath	O Sneezing
O Blocked Ear	O Masses (lumps) in groin	O Wheezing	O Itching
O Broken Nose	O Mouth breathing at night	O Mouth ulcers	O Rash
O Partials or Dentures	O Severe face pain	O Abdominal pain	O Hives
O Hearing Loss	O Frequent nosebleeds	O Nausea	O Seizures
O Change in sense of smell	O Nasal congestion	O Belching sour material	O Tremors
O Deviated Septum	O Post-nasal drainage	O Appetite is increased	O Dizziness
O Trouble swallowing	O Oral/Facial Skeletal Surgery	O Appetite is decreased	O Blacking out / Fainting
O Painful swallowing	O Sinus Pain	O Increased Thirst	O Chest pain
O Dry mouth	O Snoring (excessive)	O Fatigue	O Heart murmur
O Ear pain	O Sore Throat	O Unintentional weight loss	O Irregular Heartbeats
O Ear drainage	O Change in sense of taste	O Unintentional weight gain	O Bleed excessively
O Hearing Screen	O Hoarseness/voice changes	O Sleeping Problems	O Bruise easily
O Ringing in the ears	O Frequent dry cough	O Night sweats	
O Swollen Glands	O Frequent wet cough		

PAST IMMUNIZATIONS AND SCREENINGS: (We are required to collect this information) Darken in the bubble (O) for YES, and complete questions.

** Need (**Month / Date / Year**) for Colorectal and Colonoscopy**:**	
O Colorectal Screening: (**Month / Date / Year**)	Result of Screening Normal / Abnormal
O Colonoscopy: (**Month / Date / Year**)	Result of Screening Normal / Abnormal
O PAP Smear: Date::	Result of Screening Normal / Abnormal
O Mammogram: Year of last Mammogram (q.**2** yrs.):	Result of Screening Normal / Abnormal
O Influenza (Flu) Vaccine – Month / Year of Last Vaccine:	
O Pneumonia Vaccine (age 65 years and older) Year and Type of Vaccine (Prevnar13 or Pneumovax)	

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTO4 OR ANY MEMBERS OF HIS EMPLOY RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

PATIENT SIGNATURE:_____**DATE:**_____

REVIEWED BY:_____**DATE:**_____

PATIENT:_____ **Date:**_____

*** Patient-Provider E-mail Agreement

Either the Practice or yourself can revoke permission to use the e-mail system at any time. Please initial the response you choose below.

_____ I **DO** want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted and release this practice of any and all liability for lost information. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

_____ I **DO NOT** want to communicate with my doctor electronically.

E-mail Address: _____

*** PHYSICIAN ASSISTANT CONSENT FOR TREATMENT

This facility has a physician assistant on staff to assist on the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

“Supervision” does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and /or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan N
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions(where allowed by law)
- Making appropriate referrals

Please initial the consent below:

_____ I have read the above, and hereby **consent** to services of a physician assistant for my health care needs. I understand that at any time I can refuse to see the physician assistant and request to see a physician.

*** Primary Physician Information

[If you do not have a PCP check ____ **None**]

Name _____

Address _____

Phone _____ Fax _____

May we send information to this doctor? _____ YES _____ NO

*** Confirming Consents

By signing below, you are confirming that you have consented to the above initialed items.

Patient / Guardian Name: _____

Patient / Guardian Signature: _____

Date: _____

PATIENT:_____ **Date:**_____

Permission Authorization Form

[Only for patients that are minors under the age of 18]

Date: _____

I, _____ , give permission for the listed

individuals to bring my child, _____ , to ENTAS and Premier Sinus

and Allergy for evaluation and treatment, and for them to discuss medical conditions with the provider.

I understand that this form does NOT constitute a legal power of attorney. Any and all forms require

my signature. For identification purposes I am attaching a copy of my photo ID.

This form is valid until _____ or until further notice.

(expiration date)

Name:	Relationship:
• _____	_____
• _____	_____
• _____	_____
• _____	_____

(For your protection, we require a photo ID form the person accompanying the child.)

Signature: _____ Date: _____

Child's Legal Guardian