



EarNoseThroat
AllergySnoring
C E N T E R

Franklin M. Douglass, M.D.

Board Certified Otolaryngology, Sleep Medicine and Obesity Medicine

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 location:

- Spring Office: 6611 FM 2920 Spring, TX 7737 9

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

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

We look forward to seeing you at your appointment!

Franklin Douglass 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.

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

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lung Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unspecified Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing Loss before age 20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing Loss after age 20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bleeding / Clotting problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

<input type="checkbox"/> Fever	<input type="checkbox"/> Masses (lumps) in neck	<input type="checkbox"/> Headache	<input type="checkbox"/> Itchy eyes
<input type="checkbox"/> Chills	<input type="checkbox"/> Masses (lumps) in armpit	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Blocked Ear	<input type="checkbox"/> Masses (lumps) in groin	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Itching
<input type="checkbox"/> Broken Nose	<input type="checkbox"/> Mouth breathing at night	<input type="checkbox"/> Mouth ulcers	<input type="checkbox"/> Rash
<input type="checkbox"/> Partial or Dentures	<input type="checkbox"/> Severe face pain	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Hives
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Frequent nosebleeds	<input type="checkbox"/> Nausea	<input type="checkbox"/> Seizures
<input type="checkbox"/> Change in sense of smell	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Belching sour material	<input type="checkbox"/> Tremors
<input type="checkbox"/> Deviated Septum	<input type="checkbox"/> Post-nasal drainage	<input type="checkbox"/> Appetite is increased	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Oral/Facial Skeletal Surgery	<input type="checkbox"/> Appetite is decreased	<input type="checkbox"/> Blacking out / Fainting
<input type="checkbox"/> Painful swallowing	<input type="checkbox"/> Sinus Pain	<input type="checkbox"/> Increased Thirst	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Snoring (excessive)	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Unintentional weight loss	<input type="checkbox"/> Irregular Heartbeats
<input type="checkbox"/> Ear drainage	<input type="checkbox"/> Change in sense of taste	<input type="checkbox"/> Unintentional weight gain	<input type="checkbox"/> Bleed excessively
<input type="checkbox"/> Hearing Screen	<input type="checkbox"/> Hoarseness/voice changes	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Bruise easily
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Frequent dry cough	<input type="checkbox"/> Night sweats	
<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> 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:			
<input type="checkbox"/> Colorectal Screening: (Month / Date / Year)	Result of Screening	Normal / Abnormal	
<input type="checkbox"/> Colonoscopy: (Month / Date / Year)	Result of Screening	Normal / Abnormal	
<input type="checkbox"/> PAP Smear: Date::	Result of Screening	Normal / Abnormal	
<input type="checkbox"/> Mammogram: Year of last Mammogram (q.2 yrs.):	Result of Screening	Normal / Abnormal	
<input type="checkbox"/> Influenza (Flu) Vaccine – Month / Year of Last Vaccine:			
<input type="checkbox"/> Pneumonia Vaccine (age 65 years and older) Year and Type of Vaccine (Pevnar13 or Pneumovax)			

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTOR 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
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions(when 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