

Patient Name: \_\_\_\_\_

PCP: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**Adult Initial Visit Form (p. 1): Please provide the following medical information to the best of your ability:**

<b>Age:</b> _____	<b>DOB:</b> ___/___/___	<b>List any ALLERGIES TO MEDICATIONS:</b>	
<b>What problems are you here for today?</b>		_____	
_____		_____	
_____		_____	
<b>Past Medical History:</b>			
1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain			
	<u>Yes</u> <u>No</u>		<u>Yes</u> <u>No</u>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	_____	Bleeding disorders <input type="checkbox"/> <input type="checkbox"/> _____
High blood pressure	<input type="checkbox"/> <input type="checkbox"/>	_____	Allergy problems/therapy <input type="checkbox"/> <input type="checkbox"/> _____
Thyroid problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Kidney problems <input type="checkbox"/> <input type="checkbox"/> _____
Heart Disease/cholesterol probs	<input type="checkbox"/> <input type="checkbox"/>	_____	Neurological problems <input type="checkbox"/> <input type="checkbox"/> _____
Asthma / lung problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Cancer <input type="checkbox"/> <input type="checkbox"/> _____
Stomach or Intestinal problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Skin problems <input type="checkbox"/> <input type="checkbox"/> _____
			Other Medical Diagnosis <input type="checkbox"/> <input type="checkbox"/> _____
2) Please list any operations (and dates) you have ever had (including tonsils & adenoids):			
_____			
_____			
_____			
_____			
3) Please list any current medications on the enclosed green Patient Medication List			
<b>Social History:</b>			
	<u>Yes</u> <u>No</u>	<b>Please list details below:</b>	
Do you smoke?	<input type="checkbox"/> <input type="checkbox"/>	How much and for how long? _____	
If no, did you smoke previously?	<input type="checkbox"/> <input type="checkbox"/>	How much and for how long? _____	When did you quit? _____
Do you chew tobacco?	<input type="checkbox"/> <input type="checkbox"/>	How much and for how long? _____	
How often do you drink alcohol?		_____	What type? _____
Describe your hobbies		_____	
What is your occupation?		_____	Marital status? _____
<b>Family History:</b>			
Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:			
If yes, please indicate which relative(s) have the problem			
	<u>Yes</u> <u>No</u>		<u>Yes</u> <u>No</u>
Hearing problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Asthma or lung problems <input type="checkbox"/> <input type="checkbox"/> _____
Allergy / sinus problems	<input type="checkbox"/> <input type="checkbox"/>	_____	Heart problems <input type="checkbox"/> <input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	_____	High blood pressure <input type="checkbox"/> <input type="checkbox"/> _____
Cancer	<input type="checkbox"/> <input type="checkbox"/>	_____	Headaches <input type="checkbox"/> <input type="checkbox"/> _____
Bleeding disorders	<input type="checkbox"/> <input type="checkbox"/>	_____	Anesthesia problems <input type="checkbox"/> <input type="checkbox"/> _____
			Other health problems <input type="checkbox"/> <input type="checkbox"/> _____
<input type="checkbox"/> See attached dictation		<b>Reviewed by:</b> _____	



Patient Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**PRESENT ILLNESS** Chronology w: 1. one to three elements [level 2] 2. four to eight elements; OR status of 3 chronic or inactive conditions [level 3, 4 or 5]  
 (1) duration (2) timing (3) severity; (4) location (5) quality (6) context (7) modifying factors (8) assoc. signs & symptoms

**Nurse Hx:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Clinician Hx:**  See attached dictation

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**PHYSICAL EXAMINATION: Ear Nose & Throat**

**GENERAL** (at least 3 measurements of vital signs) HT \_\_\_ft\_\_\_in WT \_\_\_lbs  
 BP sitting-standing \_\_\_/\_\_\_mm Hg RESP \_\_\_/min TEMP \_\_\_o (F-C)  
 PULSE \_\_\_/min regular - irregular

		Normal/AB				Normal/AB	
GENERAL APPEARANCE	Stature, nutrition	<input type="checkbox"/>	<input type="checkbox"/>	NECK	MASSES & TRACHEA	Symmetry, masses	<input type="checkbox"/> <input type="checkbox"/>
COMMUNICATION & VOICE	Pitch, clarity	<input type="checkbox"/>	<input type="checkbox"/>		THYROID	Size, nodules	<input type="checkbox"/> <input type="checkbox"/>
HEAD/	INSPECTION	Lesions, masses	<input type="checkbox"/> <input type="checkbox"/>	EYES	OCULAR MOTILITY & GAZE	EOMs, nystagmus	<input type="checkbox"/> <input type="checkbox"/>
FACE	PALPATION / PERCUSSION	Skeleton, sinuses	<input type="checkbox"/> <input type="checkbox"/>	RESP.	RESPIRATORY EFFORT	Inspiratory-expiratory	<input type="checkbox"/> <input type="checkbox"/>
	SALIVARY GLANDS	Masses, tenderness	<input type="checkbox"/> <input type="checkbox"/>		AUSCULTATION	Lung sounds	<input type="checkbox"/> <input type="checkbox"/>
	FACIAL STRENGTH	Symmetry	<input type="checkbox"/> <input type="checkbox"/>	CVS	HEART AUSCULTATION	rhythm, heart sounds	<input type="checkbox"/> <input type="checkbox"/>
ENT	PNEUMO-OTOSCOPY	EACs; TMs mobile	<input type="checkbox"/> <input type="checkbox"/>		PERIPH VASC SYSTEM	Carotid pulsations	<input type="checkbox"/> <input type="checkbox"/>
	HEARING ASSESSMENT	Gross; Weber/Rinne	<input type="checkbox"/> <input type="checkbox"/>	LYMPH.	NECK/AXILLAE/GROIN/ETC.	Adenopathy	<input type="checkbox"/> <input type="checkbox"/>
	EXTERNAL EAR & NOSE	Appearance	<input type="checkbox"/> <input type="checkbox"/>	NEURO/	CRANIAL NERVES	II - XII	<input type="checkbox"/> <input type="checkbox"/>
	INTERNAL NOSE	Mucosa, turbinates	<input type="checkbox"/> <input type="checkbox"/>	PSYCH.	ORIENTATION	Person, place, time	<input type="checkbox"/> <input type="checkbox"/>
	*AFTER DECONGESTANT	Septum, OMCs	<input type="checkbox"/> <input type="checkbox"/>		MOOD & AFFECT	Comments	<input type="checkbox"/> <input type="checkbox"/>
	LIPS, TEETH & GUMS	Mucosa, dentition	<input type="checkbox"/> <input type="checkbox"/>		*ROMBERG		<input type="checkbox"/> <input type="checkbox"/>
	ORAL CAVITY, OROPHARYNX	Mucosa, tonsils, palate	<input type="checkbox"/> <input type="checkbox"/>		*TANDEM ROMBERG		<input type="checkbox"/> <input type="checkbox"/>
	HYPOPHARYNX	Mucosa, pyriforms	<input type="checkbox"/> <input type="checkbox"/>		*PAST POINTING		<input type="checkbox"/> <input type="checkbox"/>
	LARYNX (mirror: adults)	Anatomy, vc mobility	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Procedure _____ dictation / note			
	NASOPHAR. (mirror: adults)	Mucosa, choanae	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> See attached dictation			

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1. problem focused = 1-5 elements [level 1]      2. expanded = 6-11 elements [level 2]      3. detailed = 12 or more elements [level 3]  
 4. comprehensive = document every element in basic areas AND at least 1 element in each optional area [level 4 or 5]      \*optional

Patient Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**MEDICAL DECISION MAKING**  
 DATA REVIEWED (a): \_\_\_\_\_  
 :2 of the 3 sections (a vs a' vs a'', b vs b', c vs c' vs c'') must meet or exceed indicated level of care  
 :1. Minimal (level 2) 2. Limited (level 3) 3. Moderate (level 4) 4. Extensive (level 5)

Imaging: \_\_\_\_\_ Spirometry: \_\_\_\_\_  See attached dictation

Outside Records: \_\_\_\_\_ Allergy tests: \_\_\_\_\_

Audio / Tympanogram \_\_\_\_\_ Lab/blood work: \_\_\_\_\_

Other: \_\_\_\_\_

**IMPRESSIONS / DIFFERENTIAL DIAGNOSES (b):** \_\_\_\_\_ **PLANS / MANAGEMENT OPTIONS (b')** \_\_\_\_\_  
 :1. Minimal (level 2) 2. Limited (level 3) 3. Multiple (level 4) 4. Extensive (level 5)

See attached dictation

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DATA ORDERED (a'): \_\_\_\_\_  
 :1. Minimal or none (level 2) 2. Limited (level 3) 3. Moderate (level 4) 4. Extensive (level 5)  
 RTC: \_\_\_\_\_  Consultation with: \_\_\_\_\_

Audiological  Lab  CT / MRI  Other

Allergy test  IDT  Prick test  Basic Panel  Farm / Mold / Tree Panel

Test Indications: \_\_\_\_\_  Spirometry prior to test Diagnosis: \_\_\_\_\_

**RISKS DISCUSSED:**  Anaphylaxis  Beta Blocker  Bleeding  Unstable COPD / Asthma  Unstable Cardiac Status  
 Other \_\_\_\_\_  See attached dictation

Information Sheets Given: Ear Care Allergy Management Antibiotic / Acidophilus Indoor Air  
 Nasal Saline Nose Care URI info Migraine Smoking GERD Pre / post op

**COMPLEXITY OF DATA REVIEWED OR ORDERED (a'')** \_\_\_\_\_  
 :1. Minimal (level 2) 2. Limited (level 3) 3. Moderate (level 4) 4. Extensive (level 5)  
 1. min 2. limited 3. mod 4. extensive

**RISK OF COMPLICATIONS &/OR MORBIDITY OR MORTALITY (see examples in Table of Risk)**  
 :1. Minimal (level 2) 2. Low (level 3) 3. Moderate (level 4) 4. High (level 5)  
 risk of presenting problem(s) (c): 1. min 2. low 3. mod 4. high  
 risk of diagnostic procedure(s) ordered or reviewed (c'): 1. min 2. low 3. mod 4. high  
 risk of management option(s) selected (c''): 1. min 2. low 3. mod 4. high

**NATURE OF PRESENTING PROBLEM(S)**

1. minor	(level 1)	Problem runs definite and prescribed course, is transient in nature, and is not likely to permanently alter health status; OR, has a good prognosis with management and compliance.
2. low	(level 1)	Problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
3. low - mod	(level 2)	Problem where the risk of morbidity without treatment is low to moderate; there is low to moderate risk of mortality without treatment; full recovery without functional impairment is expected in most cases, with low probability of prolonged functional impairment
4. moderate	(level 3)	Problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; prognosis is uncertain, or there is an increased probability of prolonged functional impairment.
5. mod - high	(level 4,5)	Problem where the risk of morbidity without treatment is moderate to high; there is moderate risk of mortality without treatment; uncertain prognosis or increased probability of prolonged functional impairment
6. high	(level 4,5)	Problem where the risk of morbidity without treatment is high to extreme; there is moderate to high risk of mortality without treatment, or high probability of severe prolonged functional impairment.

Complete this section only if documented below >50% of visit time involved counseling and/or coordinating care.  
 TIME: \_\_\_\_\_ minutes  > 50% of visit time involved counseling and/or coordination of care

\_\_\_\_\_  
 Clinician's signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**Environment Review: Please complete details of all the sections that apply to you**

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Do you live in the city?	<input type="checkbox"/>	<input type="checkbox"/>	Do you work outdoors?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in the country?	<input type="checkbox"/>	<input type="checkbox"/>	Do you work indoors?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live on a farm?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have increased symptoms at school or work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trees and/or lawn?	<input type="checkbox"/>	<input type="checkbox"/>	List any school or work related allergy/sinus symptoms		
Do you live in a house:	<input type="checkbox"/>	<input type="checkbox"/>			
Age of house, years leved there	_____ / _____				
Do you live in an apartment/condo?	<input type="checkbox"/>	<input type="checkbox"/>			
Age and years leved there	_____ / _____		Do you use a mask when you clean, mow, or sweep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in a mobile home?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have feather pillows?	<input type="checkbox"/>	<input type="checkbox"/>
Age and years leved there	_____ / _____		Do you have down comforters?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a basement/crawl space	<input type="checkbox"/>	<input type="checkbox"/>	Do you use pillow/mattress covers?	<input type="checkbox"/>	<input type="checkbox"/>
Is it wet or dry?					
Do you have carpeting?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent exposure to:	(if yes, circle:)	
Age and amount?			Dog	<input type="checkbox"/>	<input type="checkbox"/>
Have you remodeled lately?	<input type="checkbox"/>	<input type="checkbox"/>	Cat	<input type="checkbox"/>	<input type="checkbox"/>
Do you have indoor plants?	<input type="checkbox"/>	<input type="checkbox"/>	Bird	<input type="checkbox"/>	<input type="checkbox"/>
Are there smokers in your home, apartment, or condo?	<input type="checkbox"/>	<input type="checkbox"/>	Rodents	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a hepa filter?	<input type="checkbox"/>	<input type="checkbox"/>	Livestock	<input type="checkbox"/>	<input type="checkbox"/>
What type of heating system?			Other (list)	<input type="checkbox"/>	<input type="checkbox"/>
What type of cooling system?					

PLEASE STOP HERE

See attached dictation

Reviewed by: \_\_\_\_\_

