

Duke Otolaryngology – Head & Neck Surgery

RETURN PATIENT INTAKE FORM

Thank you for filling out all sections of this form. This form is intended to update any changes since your last visit.

Today's Date: _____

Patient Name: _____ Date of Birth: _____

If your contact info has **CHANGED** since your last visit, please fill out the section below:

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

Primary Care Physician: _____ Address: _____

1. Have you noticed any CHANGE in your condition since your last visit? No / Yes / New Problem

If Yes or New Problem (complete the entire form below)

If No, there is no need to complete #2-6, please fill out #7 and sign your name at the bottom.

(Please fill out if you answered "Yes" to #1)

2. Reason for today's visit: _____

Location: Left / Right Severity: (out of 10) ____/10 Duration of Symptoms: _____

What do your symptoms feel like? _____

What have you taken or done to try to treat your symptoms? _____

What has changed since the last visit? _____

4. MEDICAL HISTORY

Have you been diagnosed with any **NEW** problems or had any surgeries since your last visit? **No / Yes.**

If so, Please list:

5. MEDICATIONS: PLEASE FILL OUT SEPARATE MEDICATION FORM.

6. DRUG ALLERGIES? Have you developed any **NEW** allergies since your last visit? **No / Yes**

If so, please list:

Drug Name	Reaction	Drug Name	Reaction
_____ / _____		_____ / _____	

7 OTHER SYMPTOMS (ROS): Please check or circle all symptoms which **YOU** are **CURRENTLY** experiencing:

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Swollen lymph nodes	<input type="checkbox"/> Rash	<input type="checkbox"/> Sleep Difficulty
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Itching	<input type="checkbox"/> Change of vision R / L
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Seizures
<input type="checkbox"/> Fever _____	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Urination Problems	<input type="checkbox"/> Depression
<input type="checkbox"/> Weakness	<input type="checkbox"/> Extremity Swelling	<input type="checkbox"/> Intolerance Cold	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Cough	<input type="checkbox"/> Throat Pain	<input type="checkbox"/> Intolerance Heat	<input type="checkbox"/> Headache
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Heartburn / Reflux	<input type="checkbox"/> Bleeding / Bruising	<input type="checkbox"/> None of the above

Patient Signature (Parent or Guardian if minor)

MD/PA Signature

Date