

## Ear Nose & Throat Associates - Triage Assessment Form New Patient

Name \_\_\_\_\_ Date \_\_\_\_\_ MR# \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Main complaint(s) (1) \_\_\_\_\_ (2) \_\_\_\_\_  
 (3) \_\_\_\_\_ (4) \_\_\_\_\_

**Level 1, 2, 3 Documentation - 1 to 3 elements**

**Level 4, 5 Documentation - 4+ elements or 3+ chronic or inactive conditions**

**History of Present Illness:**

Location \_\_\_\_\_ Timing \_\_\_\_\_ Quality \_\_\_\_\_  
 Duration \_\_\_\_\_ Severity \_\_\_\_\_ Context \_\_\_\_\_  
 Modifying factors \_\_\_\_\_  
 Associated signs/symptoms \_\_\_\_\_

**Level 1, 2, 3 Documentation - None**

**Level 4 Documentation - One area**

**Level 5 Documentation - 3 areas**

**Past Medical History:**

Hospitalizations/Surgeries:	Current Medical problems:	Pharmacy: _____	Location: _____
(1) _____	(1) _____	(1) _____	_____
(2) _____	(2) _____	(2) _____	_____
(3) _____	(3) _____	(3) _____	_____
(4) _____	(4) _____	(4) _____	_____

**Allergies:**  
 (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

**Family History:**

Does anyone in your immediate family have a history of the following?  
 If yes, please list which family member(s).  
 Allergies?  Yes  No \_\_\_\_\_  
 Asthma?  Yes  No \_\_\_\_\_  
 Heart disease?  Yes  No \_\_\_\_\_  
 Free bleeding?  Yes  No \_\_\_\_\_  
 Cancer?  Yes  No \_\_\_\_\_  
 Diabetes?  Yes  No \_\_\_\_\_  
 High blood pressure?  Yes  No \_\_\_\_\_  
 Thyroid/goiter?  Yes  No \_\_\_\_\_  
 Other \_\_\_\_\_

**Social History:**

Have you ever worked around or been exposed to loud noises?  Yes  No  
 If yes, please explain \_\_\_\_\_  
 Do you smoke?  Yes  No  
 Amount \_\_\_\_\_ Duration \_\_\_\_\_  
 Does anyone in your house smoke?  Yes  No  
 Do you use oral tobacco?  Yes  No  
 Amount \_\_\_\_\_ Duration \_\_\_\_\_  
 Do you use alcohol?  Yes  No  
 If patient is a child, is he/she in daycare?  Yes  No

**Level 1, 2, 3 Documentation - 1 system, problem pertinent**

**Level 4 Documentation - 2 to 9 systems**

**Level 5 Documentation - 10+ systems**

**Review of systems:**

<input type="checkbox"/> All Systems Normal				<i>Strike negatives</i>	<i>Circle positives</i>
<b>General:</b>	weight loss	fever	fatigue	chills	discharge
<input type="checkbox"/>	weight gain	heat/cold	intolerance	ENT:	ringing in ears
<b>Eyes:</b>	blurred vision	excessive	tearing	<input type="checkbox"/>	decrease in hearing
<input type="checkbox"/>	double vision	pain	redness	hoarseness	difficulty swallowing
<b>Cardio:</b>	trouble breathing	recent EKG's	palpitations	dizziness	infection
<input type="checkbox"/>	chest pain	short of breath	swelling	earaches	frequent colds
<b>Resp:</b>	high blood pressure	exercise intolerance		hematuria	urgency
<input type="checkbox"/>	cough	asthma	pneumonia	numbness	weakness
<input type="checkbox"/>	pain on inspiration	bronchitis	wheezing	itching	rashes
<b>GI:</b>	abdominal pain	heartburn/indigestion	constipation	skin:	color change
<input type="checkbox"/>	nausea/vomiting	difficulty swallowing	diarrhea	Neuro:	fainting/blackouts
				trouble speaking	numbness/tingling
				Hemat/Lymph:	anemia
				easy bruising	
				Aller/Immun:	allergies
				immunizations	
<b>All Systems negative except as noted</b>					

Physician Signature: \_\_\_\_\_