Returning Patient Form

Patient Name: ____ Age: ________

Pediatrician: _________________________ location: _____________________

Pharmacy: ___________________________ location: _____________________

Reason for Today's Visit – please list any items you would like to discuss with Dr. Harris

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ENT Symptoms: Patient currently having problems with any of the following:

Snoring	Dizziness	Congestion or	Sensitive to Light
Gasping in sleep	(Spinning	Stuffiness	Abnormal sense of
Hoarseness	Sensation)	Runny Nose	Smell
Cough	Ringing in Ears	Postnasal Drip	Sore Throat
Difficulty Swallowing	Off-Balance	Periodic	Lump in Neck
Hearing Loss	Earache	Nosebleeds	Mouth Ulcers
Drainage/ Bleeding	HEADACHE	Broken Nose	Pain
from ear/s		Sinus Infections	Heartburn

Systems ROS: Patient currently having problems with any of the following:

Eyes Yes No	Depression, Anxiety, etc. Yes No
Bleeding Problems Yes No	Bladder Problems Yes No
Lungs, Breathing Yes No	Epilepsy/Seizures Yes No
Numbness/Tingling Yes No	Heart Problems Yes No
Digestion, Stomach Problems Yes No	Hepatitis Yes No
Joint Aches/Pains Yes No	Appetite or Weight Change Yes No

PLEASE SIGN BELOW I certify that the above information is true and correct.

Patient/Guardian Name:____

X____

--BELOW THIS LINE FOR STAFF ONLY--

Reviewed by: ___________________________________ M.D. Date: ___________________________

Temp ______ BP _____/_____ Pulse _____ Sat _____ Resp _____ Weight _____ Height ___ ___

H/P/A/P: ____

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PLAN:____