Enticare
NEW PATIENT PACKET
REASON FOR TODAYS VISIT Checkup **DATE:** 12/02/23

RELATIONSHIP TO PATIENT: none **LEGAL GUARDIAN:** Yes
PATIENT INFORMATION:

Patient Name: Muneeb **DOB** 12-12-2000
Age: 32

Sex: (●) Male ( ) Female Marital Status: ( ) Single ( ) Married (●) Divorced ( ) Widowed ( ) Other

Mailing Address: **City:** **State:** **Zip**

Other Address: Xyz **City:** LHR **State:** Punjab **Zip** 44000

Home Phone: 032134214 **Cell Phone:** 0322349583 **Work Phone:** 0345009395

Preferred method for appointment reminders (check all that apply):
( ) Home Phone
( ) Cell Phone
( ) Text
( ) Email

Email (print clearly): yahoo@gmail.com

Pharmacy Name & City: Lht

Cross Street:
3

Phone: 03450394532
REFERRAL INFORMATION:

Referring Facility: hotel **Address / Location:** Downing street

Referring Provider Full Name: ahsan **Phone:** 03045828942

Primary Care Physician Full Name: ahsan **Phone:** 03458372942
■ Self Pay

Responsible Party/Guardian (if patient is a minor): None **Phone:** none
Primary Insurance Detail

PRIMARY INSURANCE CO: Enticare insuarance **Phone:** 03454738291

Policy Holder Name: ahsan **Group #:** first

Relationship to Patient: brother

DOB 12-24-20
Secondary Insurance Detail

SECONDARY INSURANCE CO: second Insurance

Phone: 0345028391

Policy Holder Name: Policy Name

Group #: second group

Relationship to Patient: Father

DOB
Federal Privacy Standards require the following information

Race
( ) White
(●) Hispanic
( ) Asian
( ) African American
( ) American Indian / Alaskan Native
( ) Native Hawaiian or Other Pacific Islander
( ) Other Race
( ) Unreported / Refused to Report

Ethnicity
(●) Hispanic or Latino
(No) Not Hispanic or Latino
(Re) Refused to Report

Preferred Language: (En) English (●) Spanish (Ot) Other
Otro

HIPAA APPROVED CONTACTS:

- Please list the individuals you give permission to have access to and discuss your protected health information.
- Write NONE if there are no authorized individuals.

Name: Zouraiz **DOB:** 12-3-2010 **Phone:** 034215621 **Relation to patient:** Brother

Name: Saad **DOB:** 2-3-2010 **Phone:** 0343254231 **Relation to patient:** Brother

EMERGENCY CONTACT (REQUIRED):

Name: Ahsan

DOB: 12-3-2010

Phone: 0321789234

Relation to patient: Brother

What is your Weight? 85

What is your Height? 5'10

Medications

■ None

- Please list all the medications you are taking, including supplements (attach list as needed).

Allergies

■ None

Are you allergic to:

(●) Latex
(con) Contrast Dye
(iod) Iodine

- Please list any medications you are allergic to and how each affects you.

['Ponston'] ['Ponston'] ['Ponston']

Surgery History

■ None

Have you ever had problems with anesthesia?

(●) Yes
(no) No

Please explain:
i dont have to explain

PROCEDURE
DATE (MO/YR)
menicure
2:30pm

FAMILY HISTORY

■ None

Ninguno

Please list any family history of your **Father, Mother, Siblings, Children** and **Grandparents**

CONDITION
RELATIONSHIP
Problems with anesthesia
problems with anesthesia
Thyroid disease
Thyroid Disease
Thyroid cancer
Thyroid Cancer
Throat cancer
Throat Cancer
Other cancer
Other Cancer
Early hearing loss
Early Hearing Loss
Heart disease
Heart Disease
High blood pressure
Diabetes
Stroke
Asthma
Kidney problems
Bleeding / Clotting problems
Other

SOCIAL HISTORY:

■ None
Are you a:
(non) Non Smoker
● Former Smoker
(cur) Current Smoker
If **"Former Smoker"**

How long did you smoke?2 hours

When did you quit?

If **"Current Smoker"**

How many packs per day do you smoke?1

How long have you smoked?1

Are you interested in quitting?
(yes) Yes
● No

Do you drink?
(yes) Yes
(no) No

If **Yes**: How often do you drink?
● Daily
(Few) Few per week/mo
(Ra) Rarely

RECREATIONAL DRUG USE:

(Ne) Never
(Pre) Previous
(Cu) Current
Drugs
cocaine

Last Used:
2mins ago

Female Patients Only

Are you now or is there a chance that you are pregnant?
(yes) Yes
● No
No

MEDICAL HISTORY:

ALL PATIENTS
Have you ever been DIAGNOSED with any of the following conditions?

Acid reflux (GERD) Reflujo ácido (ERGE)	● Yes Si (No) No No
Anemia Anemia	(Yes) Yes Si ● No No
Asthma Asma	(Yes) Yes Si ● No No
Atrial fibrillation Fibrilación auricular	● Yes Si (No) No No
Bronchitis, chronic Bronquitis crónica	(Yes) Yes Si ● No No
Cancer, breast Cáncer de mama	(Yes) Yes Si ● No No
Cancer, lung Cáncer de pulmón	(Yes) Yes Si ● No No
Cancer, prostate Cáncer de próstata	(Yes) Yes Si ● No No
Cancer, skin Cáncer de piel	(Yes) Yes Si ● No No
Cancer, thyroid Cáncer de tiroides	(Yes) Yes Si ● No No
Cataracts Cataratas	(Yes) Yes Si (No) No No
Congestive heart failure Insuficiencia cardíaca congestiva	● Yes Si (No) No No

Deep vein thrombosis (DVT) Trombosis venosa profunda ● Yes Si ○ No No

Dementia Demencia ○ Yes Si ○ No No

Depression Depresión ○ Yes Si ○ No No

Diabetes mellitus Diabetes mellitus ○ Yes Si ○ No No

Elevated cholesterol Colesterol elevado ○ Yes Si ○ No No

Emphysema (COPD) Enfisema ○ Yes Si ○ No No

Environmental allergies Alergias ambientales ○ Yes Si ○ No No

Epilepsy Epilepsia ○ Yes Si ○ No No

REVIEW OF SYMPTOMS:
Do you NOW have any of the following symptoms?

Fatigue Fatiga ○ Yes ● No

Fever Fiebre ● Yes ○ No

Headache Dolor de cabeza ● Yes ○ No

Sleep disturbance Trastornos del sueño ● Yes ○ No

Weight gain Aumento de peso ● Yes ○ No

Weight loss Pérdida de peso ○ Yes ● No

Congestion Congestión ○ Yes ● No

Sneezing Estornudos ○ Yes ○ No

Runny nose Secreción nasal ○ Yes ○ No

Watery eyes Ojos llorosos ● Yes ○ No

Blurred vision Visión borrosa ○ Yes ○ No

Diminished visual acuity Disminución de la agudeza visual ○ Yes ● No

Itching and redness Picazón y enrojecimiento ○ Yes ○ No

Decreased hearing Disminución de la audición ○ Yes ○ No

Decreased sense of smell Disminución del sentido del olfato ○ Yes ○ No

Difficulty swallowing Dificultad al tragar ● Yes ○ No

Dry mouth Boca seca ○ Yes ● No

Ear pain Dolor de oído ○ Yes ● No

Nose bleed Sangrado de nariz ○ Yes ● No

Ringing in ears Zumbido en los oídos ● Yes ○ No

Sinus pain Dolor de senos nasales ○ Yes ○ No

Sore throat Dolor de garganta ○ Yes ○ No

Swollen glands Glándulas inflamadas ○ Yes ○ No

Cough Tos ○ Yes ○ No

Shortness of breath at rest **Dificultad para respirar en reposo** Yes / No

Wheezing **Sibilancias** Yes / No

Irregular heartbeat **Latidos irregulares** Yes / No

Diarrhea **Diarrea** Yes / No

Heartburn **Acidez estomacal** Yes / No

Nausea **Náuseas** Yes / No

Vomiting **Vómitos** Yes / No

Easy bruising **Fácil aparición de hematomas** Yes / No

Prolonged bleeding **Sangrado prolongado** Yes / No

Joint stiffness **Rigidez en las articulaciones** Yes / No

Leg cramps **Calambres en las piernas** Yes / No

Muscle aches **Dolores musculares** Yes / No

Eczema **Eczema** Yes / No

Hives **Urticaria** Yes / No

Rash **Erupción** Yes / No

Dizziness **Mareos** Yes / No

Seizures **Convulsiones** Yes / No

Tremors **Temblores** Yes / No

EUSTACHIAN TUBE DYSFUNCTION

During the last month, how much of a problem was each of the following:
0 = no problem | 2 = moderate problem | 5 = very severe

Pressure in the ears 0 / 1 / 2 / 3 / **4**

Pain in the ears 0 / 1 / 2 / 3 / **4**

Ears feel clogged or underwater 0 / **1** / 2 / 3 / 4

Ear problems when you have a cold or sinusitis 0 / 1 / 2 / **3** / 4

Crackling or popping sounds 0 / 1 / 2 / 3 / **4**

Ringing in the ears 0 / 1 / **2** / 3 / 4

Muffled feeling in ears 0 / 1 / **2** / 3 / 4

Total Score
15
+ 7 = Mean Item Score
10

Are these symptoms in :
Le Left ear only
Ri Right ear only
Bo Both ears

THE EPWORTH SLEEPINESS SCALE

- How likely are you to doze off or fall asleep in the following scenarios in contrast to just feeling tired?
- Even if have not done some of these thing recently, try to work out how they would have affected you.
- Use the scale to choose the most appropriate number for each situation and circle the correct one.

0 = Would Never Doze
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

SCENARIO
ESCENARIO
CHANCE OF DOZING

Sitting and reading 0 / **1** / 2 / 3 / 4

Watching television 0 / 1 / **2** / 3 / 4

Sitting inactive in public place, e.g., theater or meeting 0 / 1 / 2 / **3** / 4

As a passenger in a car for an hour without a break 0 / 1 / 2 / 3 / **4**

Lying down to rest in the afternoon 0 0 1 1 2 2 3 3 4 4

Sitting and talking to someone 0 0 1 1 2 2 3 3 4 4

Sitting quietly after lunch without alcohol 0 0 1 1 2 2 3 3 4 4

In a car, while stopped in a few minutes of traffic 0 0 1 1 2 2 3 3 4 4

HEARING HISTORY QUESTIONNAIRE

Please circle the appropriate response for each symptom.

Ringing or other sounds in ears Yes No No

Chronic ear infections Yes Yes No

Earwax build up Yes Yes No

Fullness in ears Yes Yes No

Pressure in ears Yes No No

Perforated eardrum Yes Yes No No

Family history of hearing loss Yes No No

Exposed to loud noises Yes Yes No

Trauma to head Yes No No

Dizziness or vertigo Yes Yes No No

Sinus or allergy problems Yes Yes No No

Have you had a hearing test? Yes Yes No No

Have you had ear surgery? Yes Yes No No

ALLERGY HISTORY QUESTIONNAIRE

How long have you had allergy symptoms?

1week

Year-round or seasonal?

Seasonal

Have you been allergy tested before?

No

If yes, did you receive immunotherapy?

No

Are you exposed to fumes, chemicals or dust at work?

Yes

What prescription medication have you tried for allergies? For how long?

PRESCRIPTION

FOR HOW LONG

hello

10min

Ponston

10mins

Please circle the appropriate number 1-5 according to severity:

0 = no problem | 1 = mild | 5 = very severe

Nasal discharge
Secreción nasal 0 0 1 1 2 2 3 3 4 4

Nasal obstruction
Obstrucción nasal 0 0 1 1 2 2 3 3 4 4

Watery or itchy eyes
Ojos llorosos o con picazón 0 0 1 1 2 2 3 3 4 4

Sneezing
Estornudos 0 0 1 1 2 2 3 3 4 4

Wheezing
Resollar 0 0 1 1 2 2 3 3 4 4

Cough
Tos 0 0 1 1 2 2 3 3 4 4

Itching
Comezón 0 0 1 1 2 2 3 3 4 4

Eczema
Eczema 0 0 1 1 2 2 3 3 4 4

Hives
Ronchas 0 0 1 1 2 2 3 3 4 4

Headache
Dolor de cabeza 0 0 1 1 2 2 3 3 4 4

Chronic fatigue
Fatiga cronica 0 0 1 1 2 2 3 3 4 4

Food intolerance
Intolerancia a la comida 0 0 1 1 2 2 3 3 4 4

Frequent sinus or ear infections
Frecuentes infecciones de los senositis o de los oído 0 0 1 1 2 2 3 3 4 4

Frequent colds or sore throats
Resfriados frecuentes o dolor de garganta 0 0 1 1 2 2 3 3 4 4

Learning disability
Discapacidad de aprendizaje 0 0 1 1 2 2 3 3 4 4

Poor memory or concentration
Mala memoria o concentración 0 0 1 1 2 2 3 3 4 4

Hyperactivity
Hiperactividad 0 0 1 1 2 2 3 3 4 4

Abdominal gas or cramping
Gases abdominales o calambres 0 0 1 1 2 2 3 3 4 4

Arthritis or muscle aching
Artritis o dolor muscular 0 0 1 1 2 2 3 3 4 4

Asthma
Asma 0 0 1 1 2 2 3 3 4 4