David M. Vernick, MD, FACS *Harsha V. Gopal, MD, FACS* *E. Ashlie Darr, MD*

Vernick and Gopal, LLC
1244 Boylston St, Suite 303
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Tel 617-383-6800 Fax 617-383-6801

Date: _____ **New Patient Registration Form** **Acct#**_____

Demographics:

Patient's Last Name: _____ First Name: _____

Social Security # (SSN): _____-_____-_____ Male ☐ Female ☐

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

Mobile/Other: Phone: _____ Birthdate: _____/_____/_____

Marital Status: ☐ Married ☐ Divorced ☐ Single **Email:** _____

Emergency Contact: Name: _____ Relationship: _____

Best contact telephone#: _____

Insurance Information:

Primary Insurance: _____ **Secondary Insurance:** _____

Membership ID# _____ Membership ID# _____

Carrier's Name and DOB: _____ Carrier's Name and DOB: _____

Relationship to patient: _____ Relationship to patient: _____

Referral Information:

Who referred you to our office today? How did you hear about our practice?

_____

Primary Care Physician:

Name: _____ Address: _____

Telephone #: _____ Fax #: _____

Please list names of any ADDITIONAL PHYSCIANS that should receive notes from our office

1. Name: _____ Address: _____

Telephone _____ Specialty: _____

2. Name: _____ Address: _____

Telephone: _____ Specialty: _____

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Background Information

Please check as appropriate. **Federal Government Information Requirement**

Preferred Language: ☐ English ☐ French ☐ Japanese ☐ Spanish ☐ Chinese ☐ Other _____

Patient Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ Caucasian/White ☐ Other/Unspecified

Patient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other/Unspecified

Social History

Alcohol Use: ☐ Never ☐ Moderate ☐ Occasionally ☐ Social # Drinks per week: _____

Exercise Regularly: ☐ Yes ☐ No

Exposure to Fumes, Dust, Solvents or Airborne Particles: ☐ Yes ☐ No ☐ none known

Recreational Drug Use: ☐ Never ☐ Former ☐ Current

Smoking History: ☐ **Current** Every Day ☐ Current Some Days ☐ Former Smoker ☐ Never Smoker

Of Years of Active Smoking: _____ Years since quitting: _____

Other Tobacco Use? (Pipe, Cigars, Chew): _____

Pharmacy Information

Local Pharmacy Name: _____

Street Address: _____

City: _____ _____ State: _____ Zip: _____

Phone #: _____ _____ Fax #_____

Mail Order Pharmacy Name: _____ Mail Order ID: _____

Telephone # _____ Fax #: _____

Pharmacy Preference (please choose) Local Pharmacy: ☐ Mail Order: ☐

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Past Medical History

(Check the box to the left of the condition that you are currently being treated for or have been treated for in the past)

☐	Allergies (Seasonal/Environment)	☐	Deep Vein Thrombosis (DVT)	☐	Low Blood Pressure
☐	Anemia	☐	Depression	☐	Lupus
☐	Angina	☐	Dermatologic (Skin)Disease	☐	Lyme Disease
☐	Acid Reflux	☐	Diabetes	☐	Lymphoma
☐	Asthma	☐	Diverticulosis	☐	Melanoma
☐	Atrial Fibrillation	☐	Eye Disease	☐	Mitral Valve Prolapse
☐	Auto-Immune Disease	☐	Gallbladder Problems	☐	Myocardial Infarction
☐	Behavioral Disorder	☐	Gastrointestinal/GI Problems	☐	Neurological Problems
☐	Bleeding Disorder	☐	GERD/Reflux	☐	Neuropathy
☐	Blood Clots	☐	Hepatitis	☐	Pneumonia
☐	Cancer	☐	Head Injuries	☐	Renal Disease
☐	Chronic Fatigue Syndrome	☐	Headaches (migraine, cluster)	☐	Rhinitis
☐	Cardiovascular (Heart Disease)	☐	Hearing Loss	☐	Seizure Disorder
☐	Chronic Heart Failure (CHF)	☐	High Blood Pressure (Hypertension)	☐	Sinus Problems/Sinusitis
☐	Congenital Heart Disease	☐	High Cholesterol	☐	Transient Ischemic Attack (TIAs)
☐	COPD/Emphysema	☐	HIV/AIDS	☐	Thyroid Disease
☐	Coronary Heart Disease	☐	Insomnia	☐	Tuberculosis
☐	Crohns Disease	☐	Kidney/Urinary Bladder Problems	☐	Ulcers (other)
☐	Cerebral Vascular Accident (CVA)	☐	Liver Disease	☐	Ulcers (stomach)

None of the above applies: ☐ check here

Review of Symptoms (ROS):

Identify which if any of the following you are currently experiencing:

√		√		√	
☐	Abdominal Pain	☐	Frequent Nose Bleeds	☐	Rash
☐	Anxiety	☐	Headache	☐	Shortness of Breath
☐	Cough	☐	Heartburn	☐	Skin Lesions
☐	Depression	☐	Hoarseness	☐	Sore throat
☐	Difficulty Hearing	☐	Joint/Muscle Pain	☐	Vision changes
☐	Difficulty Sleeping	☐	Nausea	☐	Weight gain/loss
☐	Difficulty Swallowing	☐	Noises in Ear/Head	☐	Wheezing
☐	Fainting	☐	Pregnant	☐	

Other Symptom(s) Not Listed: _____

_____

Reason for TODAY's visit: _____

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Recent Surgical History

Have you had a tonsillectomy? Yes No Year: _____

Cancer: Specify _____

Cardiac: Specify _____

Cosmetic: Specify _____

Ear Surgery: Specify _____

Nose Surgery: Specify _____

Throat Surgery: Specify _____

Other recent Surgery: _____

Family History

Illness/Condition	Father	Mother	Brother	Sister
Family History Unknown: Check box				
Abdominal Aortic Aneurysm				
Alzheimer's Disease				
Behavioral/Emotional Health				
Bleeding Disorders				
Brain/Nervous System				
Cancer				
Diabetes				
Hearing Loss				
Heart/Cardiovascular				
Genetic Disorders				
Migraines				
Respiratory Disorders				
Stroke				

Have you ever had a pneumonia immunization? Please circle one: Yes No Unknown

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Medication History

Please list all medications that you're taking including over-the-counter medications, vitamins and other treatments. Please attach your medication list if more convenient.

Name of Medication Include over the counter medications	Dosage (mg/units/puffs/drops)

Patient reviewed and acknowledges that they are not taking any medications at this time: ☐ check here

Drug and Latex Allergies

Drug Allergies: ☐ No ☐ Yes

If yes, please list Drug name and reaction:

Drug Name: _____ Reaction _____

Drug Name: _____ Reaction: _____

Drug Name: _____ Reaction: _____

Latex Allergy: ☐ No ☐ Yes Reaction: _____

Patient/Physician Acknowledgement Signatures

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

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Name: _____ Date: _____ ACCT# _____ _____

SINO-NASAL OUTCOME TEST (SNOT-22)

1. Directions: Circle corresponding number (1,2,3,4,5). Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: ⍰⍰	No problem	Very mild problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as bad as it can be
1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Nasal obstruction	0	1	2	3	4	5
5. Loss of smell or taste	0	1	2	3	4	5
6. Cough	0	1	2	3	4	5
7. Post - nasal discharge	0	1	2	3	4	5
8. Thick nasal discharge	0	1	2	3	4	5
9. Ear fullness	0	1	2	3	4	5
10. Dizziness	0	1	2	3	4	5
11. Ear pain	0	1	2	3	4	5
12. Facial pain/pressure	0	1	2	3	4	5
13. Difficulty falling asleep	0	1	2	3	4	5
13. Wake up at night	0	1	2	3	4	5
15. Lack of a good night's sleep	0	1	2	3	4	5
16. Wake up tired	0	1	2	3	4	5
17. Fatigue	0	1	2	3	4	5
18. Reduced productivity	0	1	2	3	4	5
19. Reduced concentration	0	1	2	3	4	5
20. Frustrated/restless/irritable	0	1	2	3	4	5
21. Sad	0	1	2	3	4	5
22. Embarrassed	0	1	2	3	4	5

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Name:_____ Today's date: _____

Date of Birth:_____

Epworth Sleepiness Scale

Answer how likely are you to doze off or fall asleep in the following situations.

Answer how you felt over the past week or so.

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Number	Question
_____	1. Sitting and reading
_____	2. Watching TV
_____	3. Sitting inactive in a public place (e.g. theater or meeting)
_____	4. As a passenger in a car for an hour ride without a break
_____	5. Lying down to rest in the afternoon, when able
_____	6. Sitting and talking to someone
_____	7. Sitting quietly after a lunch, without alcohol
_____	8. In a car, while stopped for a few minutes in traffic