New Patient Intake Form

Demographic

Name: _____
Last **MI** **First**

Address: _____
Street **City** **State** **Zip**

_____
(Address Continued)

Date of Birth: ___ /___ / _____ **Cell Phone:** _____

Email: _____

Height: _____ **Weight:** _____

Preferred Pharmacy: _____
Name **Phone**

Do we have permission to access your medications from your pharmacy? ____ YES ____ NO

How did you hear about us? _____

Referring Physician Name: _____

Medical History

Chief Complaint: _____

Allergies: _____

GNO Snoring and Sinus, LLC
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Family History

____ Heart Attack	____ Hypertension
____ Obstructive Sleep Apnea	____ Bleeding Disorders

Social History

Alcohol Intake:	None	Occasional	Moderate	Heavy
Smoking Status:	Never	Former	Daily	

Past Surgical History

Surgery	Date

Past Medical History

___ Allergy	___ Hypertension
___ Asthma	___ Lung Disease
___ Bleeding Disorders	___ Migraines
___ Cancer	___ Nasal Obstruction
___ Diabetes	___ Nasal Polyps
___ Difficulty Swallowing	___ Obesity
___ Ear Infections	___ Obstructive Sleep Apnea
___ GERD/Reflux	___ Sinus Pressure
___ Headaches	___ Snoring
___ Heart Attack	

_____

Patient Signature **Date**

_____

Patient Printed Name

Epworth Sleepiness Scale

Name (Print): _____

How likely are you to doze off or fall asleep in the following situations?

Choose the most appropriate number for each situation:

0 = would never fall asleep
1 = slight chance of falling asleep
2 = moderate chance of falling asleep
3 = high chance of falling asleep

Activity	**Score**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (theater, meeting, etc.)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting quietly after lunch without alcohol	_____
Sitting and talking to someone	_____
In a car, while stopped for a few minutes in traffic	_____
Total	_____

Signature: _____

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