Stuart Selkin, MD, JD, FACS
801 Walt Whitman Road, Melville, New York 11747 (631) 692-7362

Patient Information (page 1 of 2)

Today's Date ______________________

Patient Name ______________________ Home Phone (____) ______________________

Address ______________________ Work Phone (____) ______________________

______________________ Cell Phone (____) ______________________

Birth Date ______________________ Occupation ______________________

Social Security # ______________________ Employer ______________________

Sex ☐ M ☐ F Family Physician ______________________

Spouse (or, if the patient is a minor, Parent/Guardian) information

Spouse (or Parent/Guardian) Name ______________________ Social Security # ______________________

Spouse (or Parent/Guardian) Birth Date ______________________ Phone (____) ______________________

Emergency contact information

Contact Name ______________________ Home phone (____) ______________________

Relationship ______________________ Work phone (____) ______________________

Cell phone (____) ______________________

Your Family's Medical History

☐ bleeding tendency or disorder ☐ heart disease ☐ neurologic disorder

☐ cancer ☐ high blood pressure ☐ stroke

☐ diabetes ☐ kidney disease ☐ other ______________________

Your Medical History

☐ AIDS or HIV
☐ allergy (list in space below)
  ☐ to medication
  ☐ to food
  ☐ to anything else
☐ asthma ☐ emphysema
☐ bleeding tendency or disorder
☐ cancer
☐ chemical dependency
☐ diabetes
☐ glaucoma

☐ heart disease
☐ hepatitis
☐ high blood pressure
☐ kidney disease
☐ liver disease
☐ migraine headaches
☐ neurological disorder
☐ pacemaker
☐ problems with anesthesia
  ☐ general ☐ local
☐ stroke

☐ thyroid problem
☐ tuberculosis
☐ ulcers
☐ smoker
☐ recent hospitalization
☐ surgery (list in space below)
☐ hazardous substance exposure
☐ weight loss, unintended
☐ other ______________________
____

Medications (including supplements): ____

____

Allergies (all, please): ____

Surgeries: ____

How did you learn about us? ____

Stuart Selkin, MD, JD, FACS, **801 Walt Whitman Road, Melville, NY 11747**

Reason for your visit today
(Please check all that apply)

☐ problem with ears	☐ problem with nose or sinuses	☐ problem with throat
☐ hearing loss ☐ right ☐ left ☐ both ☐ recent (a few weeks or less) ☐ long standing ☐ hearing testing done	☐ blocked nose or congestion ☐ right ☐ left ☐ both ☐ constant ☐ seasonal	☐ complete voice loss ☐ partial voice loss ☐ hoarseness ☐ pain when speaking ☐ pain when singing
☐ wax ☐ right ☐ left ☐ both ☐ use Q-tips in ears	☐ bleeding ☐ right ☐ left ☐ both ☐ only when blowing nose	☐ pain on swallowing ☐ difficulty swallowing ☐ solids ☐ liquids
☐ pain ☐ right ☐ left ☐ both ☐ constant ☐ on and off	☐ complete loss of smell ☐ partial loss of smell ☐ distortion of smell	☐ cough ☐ tickle in throat ☐ productive
☐ discharge ☐ right ☐ left ☐ both	☐ sneezing ☐ post nasal drip	☐ heartburn ☐ acid taste in mouth
☐ ringing ☐ right ☐ left ☐ both ☐ constant ☐ on and off	☐ discharge from nose ☐ right ☐ left ☐ both ☐ clear ☐color _____________	☐ lump in neck ☐ right ☐ left ☐ both ☐ painful ☐ tender
☐ dizziness or balance problem (ask for "dizziness form")	☐ pain in cheeks ☐ pain between eyes ☐ pain above eyes ☐ right ☐ left ☐ both	☐ smoker ☐ packs a day ______ ☐ pipe ☐ cigars
☐ jaw joint problem (TMJ) ☐ grind teeth	☐ sores in mouth ☐ weakness in face ☐ numbness in face	☐ frequent sore throats ☐ frequent throat clearing ☐ frequent dryness
☐ other ear problem ___________________________ ___________________________ ___________________________	☐ other nose or sinus problem ___________________________ ___________________________ ___________________________	☐ other throat problem _______________________ _______________________ _______________________
☐ fever ☐ chills ☐ muscle aches or pains ☐ fatigue		

To the best of my knowledge, the above information is correct. I will not hold Dr. Selkin or any of his staff responsible for any errors or omissions that I may have made in completing this form.

_________________________________ (signature)(parent's/guardian's signature if the patient is a minor)

_________________________________ (print patient's name)

_________________________________ (date)