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

Vernick and Gopal, LLC
1244 Boylston St, Suite 303
Chestnut Hill, MA 02467
Tel 617-383-6800 Fax 617-383-6801

Date: _____ **Patient Update 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: _____

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

Name: _____ Acct# _____

Date of Birth: _____

Reason for today's visit: _____

_____

Constitutional: Circle yes or no

Are you currently feeling in good health? Yes No

Have you experienced a recent weight loss? Yes No

Have you had a pneumonia immunization? Yes No

Medical History

Please indicate any and all conditions, either past or present.

Eyes

Red, swollen or itchy eyes _____

Ears/Nose, Mouth/Throat

Difficulty swallowing _____

Difficulty hearing _____

Noises in ears/head _____

Frequent nosebleeds _____

Respiratory

Wheezing _____

Genitourinary

Pregnant _____

Breast feeding _____

Gastrointestinal

Abdominal pain _____

Bowel habit change _____

Musculoskeletal

Joint pain or swelling _____

Limited joint movement _____

Psychiatric

Anxious _____

Depressed _____

Hematological/Lymphatic

Painful or enlarged glands _____

Bruise easily _____

Endocrine

Diabetes _____

Thyroid disease _____

Anemia _____

Angina/chest pain _____

Arthritis _____

Blood clots _____

Blood transfusion _____

Cancer _____

Chronic headache _____

Emphysema _____

Glaucoma _____

Hay Fever _____

Head injuries _____

Heart disease _____

Mitral Valve Prolapse _____

Heart Murmer _____

Heartburn _____

Hepatitis _____

High blood pressure _____

High Cholestrol _____

HIV or AIDS _____

Hives/ Rashes _____

Keloid scarring _____

Kidney disease _____

Liver disease _____

Pneumonia _____

Poor wound healing _____

Prolonged bleeding _____

Reflux _____

Seizures _____

Skin ulcers _____

Stomach ulcer _____

Stroke _____

Swelling/sore of ankles/feet _____

Tuberculosis _____

Other _____

Pharmacy

Name: _____

Address: _____

Telephone: _____

Fax: _____

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Medication	Dose/Frequency
Aspirin	
Ibuprofen	
Blood Thinners	

Allergies
Medication/Food/Seasonal

Social History

Do you smoke? _____
Have you ever smoked? _____
If yes, how many years? _____
Alcohol: Drinks/week _____
Recreational drugs _____
Exposure to fumes, solvents or airborne particles _____
Occupation _____
Marrital Status _____
Hobbies _____

Family History

Close relatives diagnosed with any of the following:

Cancer _____
Diabetes _____
Migranes _____
Heart Disease _____
Respiratory Disease _____
Bleeding Disorders _____
Hearing Loss _____

Surgeries

Have you had a tonsillectomy? _____
Date: _____

List all MD's to receive notes:

_____
Patient Name

_____
Date of Birth

_____
Patient Signature

_____
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