ENT Consultants of Marin

Kambridge P. Hribar, M.D.
1363 South Eliseo Drive, Suite A, Greenbrae, CA 94904
(415) 295-7160 Phone | (888) 960-2495 Fax

Patient Name _____

Date of Birth ____/____/____ **Sex** ___ **Recent Weight** _____ **Recent Height** _____

Address _____

City _____ **State** _____ **Zip** _____

Home phone # _____ **Cell phone #** _____ **Work phone #** _____

Email address (for appointment reminders only) _____

Is it ok to leave a voice message? Yes ☐ No ☐ If yes which number? home/cell/work

Social Security Number _____ **Driver's License Number** _____

Employer _____**Occupation** _____

Work Address _____

City _____ **State** _____ **Zip** _____

Emergency contact _____ **Phone #** _____

Relationship to patient _____

Referring Physician _____ **Primary Care Physician** _____

Preferred Pharmacy _____

Ethnicity _____ **Preferred Language ■English ☐Other** _____

I understand that my privacy is protected and I understand I have the right to request a copy of the Private Policy for ENT Consultants of Marin. ☐ YES

I understand that I am financially responsible for all of the charges whether or not paid for by my health insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of the benefits.

Signed: _____ **Date:** _____

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Reason for today's visit? _____

Personal Medical History: Please list past and current medical problems.

_____ _____ _____

_____ _____ _____

Surgical History: Please list surgeries you have had and the approximate year.

_____ _____ _____

_____ _____ _____

Family Medical History: Please list any significant medical conditions affecting family members.

_____ _____ _____

_____ _____ _____

Drug Allergies: Please list any medication you have had a reaction to.

Name of Medicine	Reaction	Name of Medicine	Reaction

Medication List:

Name	Dose	Frequency	Name	Dose	Frequency

Do you smoke? ☐ **Yes** ☐ **No If yes: packs per day?** _____ **Number of Years** ____

Did you smoke? ☐ **Yes** ☐ **No If yes: packs per day?** _____ **Number of Years** ____

Do you drink alcohol? ☐ **Yes** ☐ **No If yes, how many drinks do you have per week?** _____

Do you take drugs? ☐ **Yes** ☐ **No If yes, what and how often?** _____

How much caffeine do you have each day? _____

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Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

REVIEW OF SYMPTOMS:

General: weight change, change in strength or exercise tolerance	☐ **Yes** ☐ **No**
Head: headaches, vertigo, injury	☐ **Yes** ☐ **No**
Eyes: vision changes, double of vision, eye pain	☐ **Yes** ☐ **No**
Breast: noted lumps, tenderness, swelling, nipple discharge	☐ **Yes** ☐ **No**
Chest: difficulty breathing, wheezing, coughing up blood, cough	☐ **Yes** ☐ **No**
Heart: chest pains, palpitations, fainting	☐ **Yes** ☐ **No**
Abdomen: change in appetite, difficulty swallowing, abdominal pains, blood in stool	☐ **Yes** ☐ **No**
Genitourinary: urinary urgency, difficulty urinating, change in nature of urine	☐ **Yes** ☐ **No**
Gynecology: change in menses, vaginal discharge, pelvic pain (if female)	☐ **Yes** ☐ **No**
Musculoskeletal: pain in muscles/joints, limitation of range of motion, numbness	☐ **Yes** ☐ **No**
Neurologic: weakness, tremor, seizures, changes in mentation	☐ **Yes** ☐ **No**
Psychiatric: depressed, changes in sleep habits, changes in thought content	☐ **Yes** ☐ **No**

Other: _____