

Name	MRN	DOB	Date
Telephone H	W	M	
Pharmacy Name	Telephone		
How did you hear about us? <input type="checkbox"/> Sent by another physician (If so, please give name below.) <input type="checkbox"/> Sent by a friend <input type="checkbox"/> Internet search <input type="checkbox"/> UT and/or TSI reputation <input type="checkbox"/> Other (<i>Specify</i>)			
Physician #1 (<input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	
Physician #2 (<input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	

Important Note on Medical Records and Previous Imaging

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the nose and sinuses are very important. Please try to obtain the actual films (not just the radiology reports).

START HERE:

What symptom gives you the most trouble?

Next page →

Other Treatments

Have you seen another physician since your last visit?
 Yes
 No

If Yes, please provide details.

Medications

Please list your current medications.

Please list any other medications that you have taken since your last visit, but are not longer using.

Are you allergic to any medications?

- Yes
- No

Details

(If yes, please give details.)

Comments