

Patient's Name: _____ D.O.B. _____

Referring Physician: _____

For Women: Are you pregnant now? Yes No Possibly/Not Sure

Name and Location of Pharmacy Used: _____

List all current medications, including any over the counter (OTC) medications or supplements

Not taking any medications

NAME OF MEDICATION	DOSAGE

List any drug allergies or medicines you can not take

No known drug allergies

NAME OF MEDICATION	TYPE OF REACTION

Do you have known allergy to any of the following?

Latex Iodine Tape Contrast Agents (Dye) Other _____
 (Please describe)

Past Health History

Please indicate any diseases or problems that you have had or been diagnosed with by a doctor

No Major Illnesses

1. Childhood Diseases

- Mumps
- Measles
- Chicken Pox
- Other _____

2. Cancer

- Lung Cancer
- Breast Cancer
- Skin Cancer
- Leukemia
- Other _____

3. Congenital (Birth) Problems

- Down's Syndrome
- Heart Defect
- Prematurity (# of weeks _____)
- Other _____

4. Ears

- Chronic or Frequent Infection
- Fluid
- Hearing Loss
- Vertigo
- Other _____

5. Nose and Sinuses

- Chronic Sinusitis
- Deviated Septum
- Nasal Polyps
- Allergies
- Other _____

6. Mouth and Throat

- Chronic Tonsillitis
- Cleft Palate
- Sleep Apnea
- Other _____

7. Heart

- Atrial Fibrillation
- Chest Pain / Angina
- Heart Attack
- High Blood Pressure
- Mitral Valve Prolapse
- Heart Murmur
- Pace Maker
- Other _____

8. Lungs

- Asthma
- COPD / Emphysema
- Cystic Fibrosis
- Other _____

9. Digestive

- GERD / Reflux
- Hepatitis
- Diverticulitis
- Hemorrhoids
- Other _____

10. Skin

- Eczema
- Psoriasis
- Acne
- Other _____

11. Neurologic

- Headaches
- Stroke
- Multiple Sclerosis
- Other _____

12. Glands & Hormones

- Diabetes
- Thyroid Problem
- Other _____

13. Blood Disorder

- Low White Blood Cells
- Bleeding Disorder
- Anemia
- Low Platelets
- Other _____

14. Immune Disorder

- Rheumatoid Arthritis
- Sjogrens
- CREST
- HIV
- Other _____

15. Psychiatric History

- Depression
- Anxiety
- Mania
- Schizophrenia
- Other _____

History of any other condition not listed? _____

Surgeries / Injury

Have you ever had problems with anesthesia (being put to sleep for surgery)? Yes No

Indicate any major surgeries (if you choose OTHER please describe)

No Surgery

Eyes	<input type="checkbox"/> Cataract <input type="checkbox"/> Eyelid Surgery <input type="checkbox"/> Tear Duct <input type="checkbox"/> Lasik <input type="checkbox"/> Other:
Ears	<input type="checkbox"/> Tubes <input type="checkbox"/> Ear Drum <input type="checkbox"/> Mastoid <input type="checkbox"/> Other:
Nose	<input type="checkbox"/> Septoplasty <input type="checkbox"/> Rhinoplasty <input type="checkbox"/> Sinus Surgery <input type="checkbox"/> Other:
Throat	<input type="checkbox"/> Adenoidectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Other:
Neck	<input type="checkbox"/> Thyroidectomy
Heart	<input type="checkbox"/> Angioplasty <input type="checkbox"/> Bypass <input type="checkbox"/> Valve <input type="checkbox"/> Stent <input type="checkbox"/> Other:
Digestive	<input type="checkbox"/> Appendectomy <input type="checkbox"/> Gallbladder <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Other:
Female Health	<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Ovary Removal <input type="checkbox"/> Other:
Other	<input type="checkbox"/> Any other major surgery:

Serious injury? No Yes _____
Please Describe

Family History

Do any of your BLOOD RELATIVES have a history of:

Family History Unkown

Problems with Anesthesia

Hearing Loss after age 20

Hearing Loss before age 20

Heart Problems

Bleeding / Clotting Problems

Cancer

Other Major Health Problems _____
Please Describe

No family history problems known

Social History

Current Occupation: _____ Retired Student

Marital Status: Single Married Divorced Widowed

Tobacco Use: Never Quit Yes: Cigarette Cigar Pipe Chew

How many per day? _____

When did you start? Age: _____ or Year: _____ When did you stop? Age: _____ or Year: _____

Alcohol Use: Yes No

How many drinks per week on average? _____

Have you ever been dependent on or addicted to any drugs? Yes No

Review of Systems / Symptoms

Please indicate any other symptoms that you have now or have had in the **RECENT** past.

General

- None
- Fever
- Sleeping Problems
- Unintentional Weight Loss

Allergy Symptoms

- None
- Dust
- Moldy Places
- Pollen
- Cut Grass
- Animals
- Exercise
- Foods
- Smoke/Fumes
- Outside in Spring and/or Fall
- Outside on Windy Days
- Air Conditioning

Allergy Testing

- Never Done
- Skin Blood
- Negative
- Where Testing Done

Allergy Injections

- Never Done
- In the Past
- Currently

Other Allergies/Problems Not Listed

- _____
- _____
- _____
- _____
- _____

Please Describe

Other Medical Problems Not Listed

- _____
- _____
- _____

Facial / Eye Problems

- None
- Headaches
- Facial Pain
- Facial Weakness
- Vision Changes Not Corrected by Glasses
- Other Facial or Eye Problems:

Please Describe

Ear Problems

- None
 - Ear Pain
 - Ear Drainage
 - Hearing Loss
 - Dizziness
 - Ringing in Ears (Tinnitus)
 - Other Ear Problems:
- Infection
 - Pressure

Please Describe

Nose Problems

- Nasal Obstruction
- Nasal Congestion
- Bleeding from Nose
- Sinus Drainage
- Other Nose Problems:

Please Describe

Mouth Problems

- None
- Voice Change / Hoarseness
- Loud Snoring
- Sore Throat
- Trouble Swallowing
- Other Mouth Problems:

Please Describe

Neck Problems

- None
- Neck Mass
- Other Neck Problems:

Please Describe

Heart Problems

- None
- Chest Pain
- Lightheadedness
- Other Heart Problems:

Please Describe

Lung Problems

- None
- Frequent Cough
- Difficulty Breathing
- Other Lung Problems:

Please Describe

Stomach / GI Problems

- None
- Abdominal Pain
- Heart Burn / Indigestion
- Other Stomach / GI Problems:

Please Describe

Urinary or Female Health Problems

- None
- _____

Please Describe

Bone / Muscle Problems

- Painful Joints
- None
- Other Bone / Muscle Problems:

Please Describe

Breast or Skin Problems

- None
- _____

Please Describe

Brain or Nerve Problems

- None
- Change in Smell
- Change in Taste
- Numbness
- Weakness
- Other Brain or Nerve Problems:

Please Describe

Blood or Lymph Problems

- None
- Excessive Bleeding
- Other Blood or Lymph Problems:

Please Describe

Immune Problems

- None
- Unusual Infections
- Other Immune Problems:

Please Describe

Please Describe