



What is the reason for your visit today? \_\_\_\_\_

List all current medications, including any over the counter (OTC) medications or Supplements  Not taking any medications

Name of Medication and Dosage

List any drug allergies or medicines you cannot take  No known drug allergies

Name of Medication	Type of Reaction

Pharmacy: Name \_\_\_\_\_ Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Non- Medication Allergies**

Have you ever had allergy testing?

- No  
 Yes When: \_\_\_\_\_

Have you ever taken allergy shots?  No  Yes

Are you currently taking shots?  No  Yes

Are you allergic to any of the following?

- Latex  Tape  Foods \_\_\_\_\_  
 Other \_\_\_\_\_

### Past Health History

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

No Major Illnesses

Childhood Diseases

- Chicken Pox
- Measles
- Mumps
- Other \_\_\_\_\_

Ears, Nose & Throat

- Ear Infections
- Hearing Loss
- Sinus Infections
- Sleep Apnea
- TMJ Dysfunction
- Other \_\_\_\_\_

Digestive

- Diverticulitis
- Hemorrhoids
- Hepatitis – Type: A B C
- Irritable Bowel Syndrome
- Reflux
- Gallbladder Disease (Stones)
- Other \_\_\_\_\_

Brain/Nervous System

- Alzheimer's/Dementia
- Seizures
- Multiple Sclerosis
- Stroke
- Headache
- Other \_\_\_\_\_

Cancer

- Breast
- Leukemia
- Lung
- Other \_\_\_\_\_

Heart

- Angina (chest pain)
- Heart Attack
- Hypertension
- Murmur
- Mitral Valve Prolapse
- Other \_\_\_\_\_

Bones/Joints

- Arthritis:  Osteo  Rheumatoid
- Osteoporosis
  - Other \_\_\_\_\_

Mental/Emotional Health

- Anxiety Disorder
- Bi-Polar
- Depression
- Other \_\_\_\_\_

Allergies/Immune System

- AIDS/HIV
- Autoimmune disorder
- Lupus
- Other \_\_\_\_\_

Congenital (Birth) Problems

- Congenital Malformation
- Down's Syndrome
- Prematurity
- Other \_\_\_\_\_

Lungs

- Asthma
- COPD
- Cystic Fibrosis
- Tuberculosis
- Other \_\_\_\_\_

Skin

- Rosacea
- Acne
- Eczema
- Psoriasis
- Other \_\_\_\_\_

Glands/Hormones

- Diabetes:  Type I  Type II
- Grave's Disease
  - Thyroid Disease:  Hyper  Hypo

History of any Other Condition:

- \_\_\_\_\_

Female Patients: Are you pregnant?  Yes  No  Possibly / Not Sure

### Surgeries

Have you ever had problems with anesthesia (being put to sleep for surgery)? \_\_\_\_\_  
(Please describe)

Please indicate any ENT surgeries you have had:  No Surgery

Ears	<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Other	
Nose	<input type="checkbox"/> Rhinoplasty	<input type="checkbox"/> Septoplasty	<input type="checkbox"/> Sinus <input type="checkbox"/> Other
Mouth/Neck	<input type="checkbox"/> Tonsil / Adenoid	<input type="checkbox"/> Thyroid	Total or Partial? <input type="checkbox"/> Other

Please list any other major surgeries:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had a serious injury?  No  Yes \_\_\_\_\_  
(Please describe)

**Tests & Immunizations**

Please supply dates for all screenings and vaccinations

Pneumonia Vaccine: \_\_\_/\_\_\_/\_\_\_      Flu Vaccine: \_\_\_/\_\_\_/\_\_\_  
Colonoscopy: \_\_\_/\_\_\_/\_\_\_      Mammogram: \_\_\_/\_\_\_/\_\_\_  
PAP smear: \_\_\_/\_\_\_/\_\_\_      Bone Density Screening: \_\_\_/\_\_\_/\_\_\_

**Family History**

Please list any of your **BLOOD RELATIVES** who have a history of any of the following and give their relationship to you:

Family history unknown

	<input type="checkbox"/> No	<input type="checkbox"/> Yes	RELATIONSHIP
Problems/Complications with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems (Including Hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding/Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glands/Hormones (Diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
			(Please describe who and type)
Other Major Health Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
			(Please describe)

**Social History**

Current Occupation: \_\_\_\_\_  Disabled  Retired  Student

Marital status:  Single  Married  Divorced  Widowed  Cohabiting

Current tobacco use?

Never  Yes:  Cigarette  Cigar  Pipe  Chew

When did you start? Age: \_\_\_ or Year: \_\_\_ Average use per day \_\_\_\_\_

Quit

When did you stop? Age: \_\_\_ or Year: \_\_\_

Alcohol use?  No  Yes

Types & average number per week? Beer: \_\_\_ Wine: \_\_\_ Wine Coolers: \_\_\_  
Mixed Drinks or Liquor \_\_\_

Have you ever been dependent on or addicted to any drugs?

No  
 Yes \_\_\_\_\_  Prefer to discuss with doctor  
(Please describe)



Please answer yes or no to any other SYMPTOMS that you have now or have had RECENTLY

<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>General:</b> Fever Weight loss <input type="checkbox"/> Planned <input type="checkbox"/> Unintentional Weight gain Sleeping Problems Other: _____ <i>(Please describe)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Stomach/GI Problems</b> Abdominal Pain Constipation/Diarrhea Excessive Gas Heartburn/Indigestion Other: _____ <i>(Please describe)</i>
<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Eye Problems:</b> Blurred vision Double vision Itching/Burning Other: _____ <i>(Please describe)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Urinary or Female/Male Problems</b> Difficulty Starting/Stopping Stream Frequency/Urgency Incontinence Pain/Bleeding Other: _____ <i>(Please Describe)</i>
<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Ear Problems:</b> Dizziness Drainage Hearing Loss Infection Itching Pain Ringing Other: _____ <i>(Please describe)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Bone/Muscle problems:</b> Painful Joints Pain/Stiffness in Neck Weakness Other: _____ <i>(Please Describe)</i>
<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Nose Problems:</b> Nasal Congestion Itching Nosebleeds Postnasal Drainage Other: _____ <i>(Please describe)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Breast or Skin problems:</b> Change in Moles Dry/Itchy Skin Rash Sores Other: _____ <i>(Please describe)</i>
<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Mouth Problems:</b> Bad Breath Dryness Hoarseness or Other Voice Change Snoring Sore Throat Swallowing Difficulty Other: _____ <i>(Please describe)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Brain or Nerve Problems:</b> Change in smell Change in taste Change in Vision NOT Corrected with Glasses Memory Loss Headache Numbness Facial Pain Weakness Other: _____ <i>(Please describe)</i>
<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Heart Problems</b> Lightheadedness Chest Pain Irregular Heartbeat/Palpitations Other: _____ <i>(Please describe)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Blood or lymph problems:</b> Excessive Bleeding Easy bruisability Neck Mass/Swelling Other: _____ <i>(Please describe)</i>
<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Lung Problems:</b> Frequent Cough Difficulty Breathing/Short of Breath Other: _____ <i>(Please describe)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<b>Immune Problems:</b> Hives Unusual Infections Other: _____ <i>(Please describe)</i>
					<b>Other medical problem not listed:</b> _____ _____ <i>(Please describe)</i>