PATIENT HISTORY

****If you need assistance completing this form, please see the front desk****

❖ **Reason for today's visit:**

_____

_____

❖ **Allergies: NONE_____**

Drug: _____ Reaction: _____
Drug: _____ Reaction: _____
Drug: _____ Reaction: _____

Environmental:
Have you been allergy tested? Yes _____ No _____
If yes, please explain: _____

_____

❖ **Current Medications (Please include supplements and vitamins):**

_____ _____
_____ _____
_____ _____
_____ _____

❖ **Family History:**

Asthma	Yes	No	Diabetes	Yes	No
Bleeding Disorder	Yes	No	Hay Fever/Allergies	Yes	No
Cancer _____	Yes	No	High Blood Pressure	Yes	No
Heart Disease	Yes	No	Other _____		

❖ **Social History:**

Do you:
Use alcohol: _____ Yes ____No
How often: _____
Caffeine Intake: ____ Yes ____ No _____Amount

Use tobacco: _____ Yes _____No _____Former
Type: Cigarettes Cigar Pipe Chew (circle one)
Packs/Number per day _____Years of use _____

❖ **Surgical History:**

Sinus Surgery: _____ Year: _____
Other: _____ Year: _____
Other: _____ Year: _____

❖ **Medical History:**

Do you have or have you ever been diagnosed with:

Acid Reflux	Y/N	Diabetes	Y/N	Immune System Disorder	Y/N
Arthritis	Y/N	Emphysema	Y/N	Migraines	Y/N
Asthma	Y/N	Glaucoma	Y/N	Sleep Disorder	Y/N
Bleeding Disorder	Y/N	Hay Fever	Y/N	Stroke	Y/N
Cancer	Y/N	Heart Murmur	Y/N	Thyroid Problems	Y/N
Chest Pain/Heart Attack	Y/N	High Blood Pressure	Y/N	Other _____	

❖ **Review of Systems:**

Please check ALL that CURRENTLY apply:

Ears, Nose and Throat:

- **EAR:** **NONE ____** Hearing Loss ____ Ear Pain ____ Ear pressure ____ Draining Ear(s) ____

- **NOSE:** **NONE ____** Runny Nose ____ Stuffy Nose ____ Nosebleed ____ Snoring ____ Post Nasal Drip ____ Sinus Infection ____

- **Throat:** **NONE ____** Cough ____ Hoarseness ____ Sore Throat ____ Difficulty swallowing ____Sores in Mouth ____ Grind Teeth ____ Tooth Pain ____

Allergic/Immunologic: **NONE ____** Seasonal Allergies ____ Hay Fever ____

Neurologic: **NONE ____** Frequent Headaches ____ Dizzy/Vertigo ____ Ringing in the Ear(s) ____

Constitutional: **NONE ____** Fatigue ____ Fever ____ Frequent Colds ____ Weight gain ____(____lbs.) Weight loss___(____lbs.)

Eyes: **NONE ____** Blurred Vision ____ Double Vision ____ Itching ___ Burning ____ Eye Pain ____

Cardiovascular: **NONE ____** Chest Pain ___ Irregular Heartbeat ___ Heart Murmur ___

Lungs: **NONE ____** Wheezing ____ Shortness of Breath ____ Coughing Up Blood ____ Phlegm ____

GI/GU: **NONE ____** Vomiting ____ Heartburn ____ Loss of Appetite ___ Difficulty Urinating ____

Musculoskeletal: **NONE ____** Muscle Pain ____ Joint Pain ____ Arthritis ____

Integumentary: **NONE ____** Rash ____ Bruise Easily ____

Psychiatric: **NONE ____** Depression ____ Anxiety ____

Endocrine: **NONE ____** Excessive Thirst ____ Excessive Sweating ____

Hematologic/ Lymphatic: **NONE ____** Swollen Glands ____

Other: **NONE ____** Pregnant ____ Nursing ____