

Name: _____ Age: _____ Referred by: _____

Reason for visit? _____ Duration of symptoms: _____

Describe the problem _____

Medications: (List current medications and dosages)

- 1) _____ 6) _____
- 2) _____ 7) _____
- 3) _____ 8) _____
- 4) _____ 9) _____
- 5) _____ 10) _____

Medication Allergies:

Other Allergies:

Do you take aspirin/ibuprofen/pain medication regularly? Yes No If yes, drug and dosage: _____

Have you ever had allergy testing? Yes No

Are you pregnant? Yes No

Do you receive allergy shots? Yes No

Past Medical History: (List with dates)

Illnesses/Medical problems (eg. Diabetes, heart disease):

Injuries:

Hospitalizations:

Blood transfusions:

Adverse reactions to Anesthesia:

Surgery:	Operation _____	Hospital _____	Year _____
	Operation _____	Hospital _____	Year _____
	Operation _____	Hospital _____	Year _____
	Operation _____	Hospital _____	Year _____
	Operation _____	Hospital _____	Year _____

Social History:

- Occupation _____ Marital status _____
- Do you smoke? Yes No Packs per day: _____ How many years: _____
 - Do you use oral tobacco? Yes No Times per day: _____ How many years: _____
 - Do you or have you used any other drugs? Yes No Be specific: _____
 - Do you drink alcohol? Yes No Drinks per day: _____ How many years: _____
 - Do you drink caffeine (coffee, tea, soda)? Yes No Drinks per day: _____
 - How much water do you drink per day? _____ cups

Family History: (check all that apply)

- Diabetes Tuberculosis High blood pressure Stroke Allergies Thyroid disorder Thyroid cancer Asthma
- Hearing loss Heart disease Cancer (type) _____ Bleeding problems
- Problems with anesthesia (be specific) _____

Review of Symptoms: (Check all that apply)

- EARS: Hearing loss Ringing/roaring Dizzy Pain Drainage Hearing aid Ear pressure
 Exposure to loud noises
- NOSE: Congestion Bleeding Change in smell Post nasal drip Facial pain Nasal discharge
- THROAT: Pain Difficulty swallowing Voice change Tonsillitis Snoring Throat clearing
 Heartburn/indigestion Lump in throat Cough
- NECK: Mass Thyroid nodule Injury Pain
- GENERAL: Headache loss of vision Glaucoma Stroke Paralysis Cough Shortness of breath
 Asthma Emphysema Tuberculosis Heart attack Chest pain Heart failure
 High blood pressure Abnormal heart beats Kidney disease Kidney stones Stomach ulcers
 Hepatitis Diarrhea Constipation Diabetes Psoriasis Eczema Skin rash Anemia
 HIV/AIDS Easy bleeding/bruising Lyme disease

Is there anything else about your medical history that your doctor should know?

I have reviewed this information and find it to be correct. Patient _____ Date _____

Doctor _____ Date _____