

NAME: _____ BIRTH DATE: _____ TODAY'S DATE: _____

WEIGHT: _____ HEIGHT: _____ DATE OF LAST PHYSICAL EXAMINATION: _____

IMPORTANT: PLEASE LIST REASONS FOR TODAY'S VISIT: _____

NASAL PROBLEMS:

Do you have a stuffy nose? Y N OCC
Are you a mouth breather? Y N OCC
Do you have any nasal discharge Y N OCC
Is it clear? Y N OCC
Off color (yellow)? Y N OCC

EAR PROBLEMS:

Does your hearing seem normal? Y N
If not, which is your best ear? R L
Do you have ringing or noises in your ears? Y N
Is it worse on one side? R L
Are you dizzy? Y N

THROAT PROBLEMS:

Hoarseness: Y N
Duration: _____
Trouble swallowing: Y N
Duration: _____
Foreign Body Sensation: Y N
Duration: _____

SLEEP PATTERN:

Do you sleep well? Y N
Do you snore? Y N
Badly? Y N
Appetite: Good _____ Fair _____ Poor _____
Weight: Stable _____ Gain _____ Loss _____
Salt and salty foods: Light _____ Moderate _____
Heavy _____

Do you have problems with chronic headaches? Y N
Have you ever had a problem with a drug habit? Y N
Alcoholic Beverage Consumption: Never _____ Rarely _____ Moderate _____ Heavy _____
Do you or have you ever smoked? Y N How much? _____

What x-rays, if any, have you had in the last two years? _____

Have you ever had any serious injury? _____

Have you ever been hospitalized for anything other than surgery? _____

SURGERY:

Have you ever had a Tonsillectomy? Y N Date _____
Appendectomy? Y N Date _____
Gall Bladder? Y N Date _____
D&C? N/A Y N Date _____
Hysterectomy? N/A Y N Date _____
Ovarian Surgery? N/A Y N Date _____
Tubal Ligation? N/A Y N Date _____

Please list any other surgeries you may have had: _____

Have you ever had, or do you now have:

Eye problems? Y N Describe _____
Heart trouble? Y N Describe _____
Liver trouble? Y N Describe _____
Stomach trouble? Y N Describe _____
Lung trouble? Y N Describe _____
Prostate trouble? Y N Describe _____
Kidney/Bladder trouble? Y N Describe _____
Nervous system? Y N Describe _____
Unexplained weight loss/gain? Y N Describe _____
Rashes/skin trouble? Y N Describe _____
Depression/Psychiatric trouble? Y N Describe _____
Easy bleeding/bruising? Y N Describe _____

Have you ever been exposed to Hepatitis? Y N When _____
HIV Virus? Y N When _____
AIDS? Y N When _____

MEDICATIONS:

NAME AND DOSE

"Sinus" medications	Never ____	Occ. ____	Freq. ____	_____
Nose sprays	Never ____	Occ. ____	Freq. ____	_____
Tranquilizers	Never ____	Occ. ____	Freq. ____	_____
Sleeping pills	Never ____	Occ. ____	Freq. ____	_____
Aspirin (not Tylenol)	Never ____	Occ. ____	Freq. ____	_____
Cortisone	Never ____	Occ. ____	Freq. ____	_____
Thyroid	Never ____	Occ. ____	Freq. ____	_____

Have you ever taken insulin or tablets for diabetes? Y N

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

ALLERGIES:

Are you allergic to:

Sulfa	Y	N	
Penicillin	Y	N	
Aspirin	Y	N	
Codeine	Y	N	
Morphine	Y	N	
Antibiotics	Y	N	Please specify name of antibiotic you are allergic to: _____

Please list any other drug allergies: _____

Please list any other allergies such as hay fever, etc.: _____

Have you ever had allergy testing? Y N If yes, when? _____

Have you ever taken allergy shots? Y N If yes, when? _____

FAMILY HISTORY:

Father's Age _____ if deceased, cause of death: _____

Mother's Age _____ if deceased, cause of death: _____

Do any of your blood relatives have:

Diabetes?	Y	N	Who? _____
Bleeding Disorder?	Y	N	Who? _____
Tuberculosis?	Y	N	Who? _____
Cancer?	Y	N	Who? _____
Inherited Abnormalities	Y	N	If yes, please list the abnormality _____

How many children do you have? _____ N/A

Please list all ages: _____

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE GIVEN WRITTEN PERMISSION TO DO SO. THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM.