Patient Name:_____ **DOB:**_____ **Today's Date:** _____

Family History

*Please indicate any illnesses that run in your **immediate family** (parents/siblings/children)*

☐ Anesthesia reactions ☐ Diabetes ☐ Migraines ☐ Cancer: *Specify type*

☐ Bleeding disorder ☐ Environmental allergies ☐ Thyroid disorder: *Specify type*

Past Medical History

☐ ***None***

Head
☐ Trauma
Eyes
☐ Cataracts
☐ Glaucoma
Ears
☐ Hearing aids
Nose / Sinuses
☐ Allergic Rhinitis
☐ Sinus Infections
Mouth / Throat / Teeth
☐ Dentures
☐ Dental Implants
Cardiovascular
☐ Aneurysm
☐ Deep Vein Thrombosis
☐ HTN (Hypertension)
☐ Murmur
☐ Myocardial infarction
☐ Other heart disease

Respiratory
☐ Asthma
☐ Bronchitis
☐ COPD
Gastrointestinal
☐ Cirrhosis
☐ GERD / Reflux
☐ Gallbladder disease
☐ Heartburn
☐ Hepatitis
☐ Ulcer
Genitorurinary
☐ Hernia
☐ Kidney Stones
☐ Other kidney disease

Misc:
☐ Nasal trauma
☐ Sjögren's Syndrome
☐ Dental cavity/disease

Musculoskeletal
☐ Arthritis
Skin
☐ Dermatitis / Eczema
☐ Mole(s)
☐ Psoriasis
Neurological
☐ Epilepsy
☐ Seizures
☐ Severe headaches, migraines
☐ Stroke
☐ TIA
Psychiatric
☐ Bipolar disorder
☐ Depression
☐ Dementia
☐ Other psychiatric

☐ Hyperthyroidism
☐ Bleeding Disorder

Cancer / Hematology
☐ Anemia
☐ Cancer
Specify:

Endocrine
☐ Goiter
☐ Hypothyroidism
☐ Thyroid Disease
☐ Thyroiditis
☐ Type I Diabetes
☐ Type II Diabetes
Infections
☐ HIV
☐ Sexually transmitted disease--*Please name*:

Additional info or other:

Current Health Problems You May Have (ROS)

☐ ***I do not have these problems***

Constitutional
☐ Fever
☐ Involuntary weight gain or loss
☐ Difficulty with anesthesia
Eyes
☐ Watery or itchy
☐ Decreased vision
☐ Double vision
Sleep
☐ Snoring
☐ Sleep apnea
☐ Other trouble with sleep

Ear, Nose, Mouth, Throat
☐ Ear pain
☐ Ear drainage
☐ Ringing or sounds in one/both ears
☐ Hearing loss
☐ Vertigo
☐ Nasal obstruction
☐ Nasal congestion
☐ Nasal drainage
☐ Postnasal drip
☐ Sore throat
☐ Difficult or painful swallowing
☐ Hoarseness
☐ Lump/Swelling on head or neck

Cardiovascular
☐ Chest pain
☐ Shortness of breath
☐ High blood pressure
☐ Mitral valve prolapse
☐ Antibiotics needed before dental procedure
Respiratory
☐ Asthma
☐ Wheezing
☐ Cough
Gastrointestinal
☐ Heartburn/acid reflux
☐ Blood in vomit
Genitourinary
☐ Difficulty w/urination

Musculoskeletal
☐ Muscle aches
☐ Arthritis
Integumentary
☐ Skin rashes
☐ Other skin disorder
Neurological
☐ Headaches
☐ Numbness
☐ Fainting
☐ Balance difficulty
Psychiatric
☐ Depression
☐ Anxiety
☐ Bipolar disorder
☐ Other:

Endocrine
☐ Heat or cold intolerance
☐ Frequent urination
☐ Excessive thirst
Hematologic/Lymph.
☐ Easy bleeding/bruise
Allergy/Immunologic
☐ Environmental allergies
☐ Allergy test done
☐ Immune system problems
Explain any answers or list other health problems, if needed:

Vaccinations: ☐ Influenza, Date: _____ ☐ Pneumonia, Date: _____

Today's date: _____

Patient Name: _____ **DOB**: _____ **Email:**_____

Primary care physician:_____ **Pharmacy:** _____
Name City/Intersection

Referred by: _____ **Pharmacy Ph#**: _____

Reason for today's appointment: _____

_____

_____

When did symptom(s) first occur?_____

List medications you are/have taken for **this problem**:_____

List recent testing for **this problem:** _____

Please list any **medications / vitamins / supplements you take regularly** *(including Aspirin, Ibuprofen, Tylenol, etc):*

☐ I do not take any medications, vitamins, or supplements ☐ A list of my medications is attached

Drug name	Strength	Frequency	Drug name	Strength	Frequency

Please list all **ALLERGIES** (drug, environmental, food): _____

_____

_____ ☐ No Known Allergies

Past Surgical History

☐ ***I've never had surgery***

☐ Aneurysm repair	☐ Cataract/lens surgery	☐ Knee arthroplasty	☐ Sinus surgery—*specify:*
☐ Appendectomy	☐ Cesarean section	☐ Laminectomy	
☐ Back surgery	☐ Dental implant *	☐ Nasal surgery—*specify:*	☐ Skin cancer excision
☐ Bilateral Tubal ligation	☐ Ear tube placement *		☐ Spinal fusion
☐ Coronary artery bypass graft	☐ Hip arthroplasty	☐ PTCA – Cardiac stent	☐ Tonsillectomy
☐ Carotid stent/endarterectomy	☐ Hip replacement	☐ Pacemaker / defibril.	☐ Thyroidectomy *
	☐ Hysterectomy		☐ Tracheotomy *

Other *(specify)*:

Social History

Tobacco
☐ Never used tobacco
☐ Chewing tobacco
☐ Cigar
☐ Currently smoke
packs per day:
☐ Quit; ___ years ago
Formerly smoked

Alcohol
☐ Do not drink
☐ Drink < 5 per month
☐ Drink daily; ___ per day

Drug Abuse
☐ IV drug user
☐ Illicit drug use

Cardiovascular
☐ Eat healthy meals
☐ Exercise regularly
☐ Take daily aspirin

Who else lives with you? *Please specify*

_____# packs per day: