Welcome to our practice. Our goal is to provide you or your child with the highest quality of care. The first step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete the following 2 pages . Our staff would be glad to assist you if needed. The care we give you can be no better than the information you provide.

Patient Name: _____ **DOB:**_____ **Date:**_____

Who Referred you to us? ☐ Primary Physician ☐ Other Physician(s) ☐ Friend/Family Name:_____

Main Reason For Visit: Briefly describe_____

How Long have the symptoms been present?_____

What makes it better or worse?_____

Have you taken any medications for this condition?_☐_Yes ☐ No If Yes, what kind?_____

How often do you have these symptoms?_____

Medication Allergies	Type of Reaction		Medication Allergies	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No

Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone)_____

***MEDICAL / SURGICAL HISTORY*: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

☐ **No Past Medical History**

Cardiovascular:
Coronary Artery Disease ☐ **Yes**
Elevated cholesterol (hyperlipidemia) ☐ **Yes**
High Blood Pressure (hypertension) ☐ **Yes**

Gastrointestinal:
Hepatitis ☐ **Yes**
Hernia ☐ **Yes**
Gastroesophageal Reflux ☐ **Yes**

Genitourinary:
Prostate enlargement (Prostatitis) ☐ **Yes**
Kidney Stones (Nephrolithiasis) ☐ **Yes**
Acute Renal Failure ☐ **Yes**

Ear / Nose / Throat: (HEENT)
Cataracts ☐ **Yes**
Glaucoma ☐ **Yes**
Chronic ear infections (otitis media) ☐ **Yes**
Hearing loss ☐ **Yes**
Sinus problems (chronic sinusitis) ☐ **Yes**
Nasal polyps ☐ **Yes**
Nasal allergies ☐ **Yes**
Recurrent tonsillitis ☐ **Yes**
Tinnitus ☐ **Yes**
Vertigo ☐ **Yes**

Hematologic :
Anemia ☐ **Yes**

Immunologic:
Allergies Type: _____ ☐ **Yes**
Food Allergies Type: _____ ☐ **Yes**
HIV / AIDS ☐ **Yes**

Infectious Disease:
Mononucleosis ☐ **Yes**
STD Type: _____ ☐ **Yes**

Metabolic/endocrine:
Diabetes Type: _____ ☐ **Yes**
Thyroid deficiency (hypothyroidism) ☐ **Yes**
Thyroid excess (hyperthyroidism) ☐ **Yes**

Neoplastic:
Cancer Type: _____ ☐ **Yes**

Neurologic:
Migraine ☐ **Yes**

Obstetric:
Pregnancy Date(s): _____ ☐ **Yes**

Psychiatric:
Adjustment Disorder - Anxiety ☐ **Yes**
Major Depression ☐ **Yes**

Pulmonary:
Asthma ☐ **Yes**
COPD/Emphysema ☐ **Yes**
Sleep Apnea ☐ **Yes**
Tuberculosis ☐ **Yes**

Miscellaneous:
Anesthesia Reaction ☐ **Yes**

Miscellaneous PEDIATRIC:
Complications during Pregnancy ☐ **Yes**
Complications during Delivery ☐ **Yes**
NICU stay >48hrs:_____ ☐ **Yes**
Preterm birth ☐ **Yes**

***SURGICAL HISTORY*: HAVE YOU EVER HAD ANY OF THE FOLLOWING SURGERIES?**

Tonsillectomy ☐ **Yes**
Adenoidectomy ☐ **Yes**
Ear Tubes ☐ **Yes**
Nasal Septoplasty ☐ **Yes**
Sinus Surgery ☐ **Yes**
Mastoid Surgery ☐ **Yes**
Palate Surgery ☐ **Yes**
Heart Bypass ☐ **Yes**
Heart Stent ☐ **Yes**
Pacemaker Surgery ☐ **Yes**

Please List Any Other Surgeries

_____

_____

_____

_____

FAMILY HISTORY:

Hearing deficiency	☐ **Yes**	Seizure disorder	☐ **Yes**
Hyperlipidemia	☐ **Yes**	High Blood Pressure	☐ **Yes**
Allergies	☐ **Yes**	Irritable Bowel Syndrome	☐ **Yes**
Asthma	☐ **Yes**	Migraines	☐ **Yes**
Blood disease	☐ **Yes**	Osteoarthritis	☐ **Yes**
CAD (Coronary Artery Disease)	☐ **Yes**	Osteoporosis	☐ **Yes**
Cancer Type: _____	☐ **Yes**	Kidney disease	☐ **Yes**
CVA (Stroke)	☐ **Yes**	Eczema	☐ **Yes**
Diabetes	☐ **Yes**	Other: _____	

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**
If Yes, What Kind? ☐ **Cigarettes** ☐ **Cigars** ☐ **Pipe** ☐ **Oral** **Do you consume alcohol?** ☐ **Yes** ☐ **No** ☐ **Former**
_____packs/cans per day _____Yrs of Using **_____drinks per week (average)**
Exposed to second hand smoke? ☐ **Yes** ☐ **No**
Caffeine Consumption? ☐ **Yes** ☐ **No** **Which type? Coffee / Tea / Colas** **How many per day? _____**

REVIEW OF SYSTEMS: Check any of the following problems you have recently had:

General health problems
☐fatigue ☐fever ☐night sweats ☐unintentional weight loss ☐sleeping problems ☐weight gain

Eye problems
☐double vision ☐itchy eyes ☐swelling ☐redness

Ear problems
☐ear drainage ☐hearing loss ☐ear infections ☐dizziness ☐itchy ☐noise exposure ☐ringing /noise in ears ☐ear pain ☐tinnitus

Nose & Sinus problems
☐chronic congestion ☐mouth breathing ☐nosebleeds ☐frequent sneezing ☐runny nose ☐post-nasal drip

Mouth & Throat problems
☐difficulty swallowing ☐snoring ☐sore throat ☐hoarseness ☐sores in mouth ☐ulcers

Heart or circulation problems
☐heart murmur ☐leg cramping ☐swelling of ankles ☐chest pain ☐blacking out ☐irregular heartbeat

Lung or respiratory problems
☐shortness of breath ☐wheezing ☐ cough

Stomach problems
☐abdominal pain ☐diarrhea ☐heartburn ☐nausea ☐vomiting

Brain or Nervous system problems
☐headache ☐seizures ☐weakness ☐numbness ☐facial pain

Glands & Hormone problems
☐intolerance to heat ☐increased appetite ☐neck enlargement ☐intolerance to cold

Blood or Lymph nodes problems
☐bleeds excessively after injury ☐bruises easily

Allergy problems
☐food intolerances ☐insect bites

Skin
☐rash ☐itchy ☐latex allergies ☐swelling ☐urticaria / hives

DO NOT WRITE IN THIS SECTION **FOR STAFF USE ONLY**

EXAM **Vitals** **Temp_____HR_____RR_____BP_____**

MOOD/AFFECT approp/non		NOSE Ext	Lesion Shift R L	NECK	Soft Supple mass R L
A&Ox3 Yes No		SEPTUM	Straight Dev R L		Node R L Shoddy
Skin	Moist Dry Flaking		Obstruct %	SUBMAX	Soft Mass Ptotic R L
Scalp	Dry Flaking Oily Ulcers	TURBINATES	Pink Edema Enlarged	PAROTID	Soft Mass Tendr R L
Voice	Clear Hoarse Breathy	NSL MUCOSA	Pink Red Rhinorrhea	THYROID	Soft Large Nodule
Eyes	EOMI PERRLA Entrap L R		Pus	CRANIAL N	3-12 Intact Defect
REAC	Clear Wax Dry Wet Pus Fungi	LIPS	Moist Dry Lesion	TMJ	Mobile Tender R L
LEAC	Clear Wax Dry Wet Pus Fungi	TEETH/GUMS	Good Repair Edentu	LARYNX	Symetry Mass Nodule
RTM	Pearly Dull Retract Perf		Caries Inflammed		Polyp Paralysis R L
	AOM SOM Sclerosis	TONSILS	0 1 2 3 4 Pus/Exud		LPR 1 2 3 4 5 6 7 8 9 10
LTM	Pearly Dull MEE Retract Perf	PALATE	Healthy Narrow Long	LUNGS	CTA Rhonchi Wheeze
	AOM SOM Sclerosis	TONGUE	PinkRed Large Lesion	HEART	RRR Murmur Arrythm

Physician Signature_____