**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTH DATE: \_\_\_\_\_\_\_\_ TODAY’S DATE: \_\_\_\_\_\_\_\_**

**WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ DATE OF LAST PHYSICAL EXAMINATION: \_\_\_\_\_\_\_\_\_\_\_\_**

**IMPORTANT: PLEASE LIST REASONS FOR TODAY’S VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NASAL PROBLEMS: THROAT PROBLEMS:**

Do you have a stuffy nose? Y N OCC Hoarseness: Y N

Are you a mouth breather? Y N OCC Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any nasal discharge? Y N OCC Trouble swallowing: Y N

Is it clear? Y N OCC Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Off color (yellow)? Y N OCC Foreign Body Sensation: Y N

Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EAR PROBLEMS: SLEEP PATTERN:**

Does your hearing seem normal? Y N Do you sleep well? Y N

If not, which is your best ear? R L Do you snore? Y N

Do you have ringing or noises Badly? Y N

in your ears? Y N Appetite: Good \_\_ Fair \_\_ Poor \_\_

Is it worse on one side? R L Weight: Stable \_\_ Gain \_\_ Loss \_\_

Are you dizzy? Y N 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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. \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tranquillizers 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_