

PATIENT HISTORY FORM

Last Name: _____ First Name: _____ Middle: _____

Social Security No. _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

What is the reason for your visit today? _____

PAST MEDICAL HISTORY

List your present medications (include over-the-counter):

Medication	Dosage/Frequency	Medication	Dosage/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you on a blood thinner? Yes ___ No ___

List all past/present medical illnesses:

List previous surgeries/hospitalizations:

Surgery/Hospitalization	Approximate Date
_____	_____
_____	_____
_____	_____

List all allergies (medication, food, etc.):

Date of: Last chest x-ray? ___/___/___ Prior EKG? ___/___/___ Prior allergy test ___/___/___

SOCIAL HISTORY

Marital Status? Married ___ Single ___ Divorced ___ Widowed ___

Do you: Smoke yes ___ No ___ If yes, how many packs per day ___
Drink yes ___ No ___ If yes, circle one: wine beer whiskey
Chew yes ___ No ___

Are you a previous smoker? yes ___ No ___ If yes, when did you quit? _____

Do you have a history of alcohol or substance abuse? Yes ___ No ___

FAMILY HISTORY

List all serious illnesses in your immediate family (diabetes, cancer, heart disease, high blood pressure, asthma, etc.)

Illness

Family Member

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following? Circle Yes or No.

<p>Ear:</p> <p>Decreased Hearing Y N</p> <p>Pain Y N</p> <p>Fullness Y N</p> <p>Nose:</p> <p>Blockage/Breathing Y N</p> <p>Congestion Y N</p> <p>Drainage Y N</p> <p>Infection Y N</p> <p>Trauma Y N</p> <p>Sneezing Y N</p> <p>Bleeding Y N</p> <p>Loss of Smell Y N</p> <p>Throat:</p> <p>Lumps/Growth Y N</p> <p>Pain Y N</p> <p>Swelling Y N</p> <p>Abscess Y N</p> <p>Tonsillitis Y N</p> <p>Hoarseness Y N</p> <p>Voice Change Y N</p> <p>Loss of Voice Y N</p> <p>Sinus:</p> <p>Eye/Facial Swelling Y N</p> <p>Change in Vision Y N</p> <p>Pain Y N</p> <p>Pressure Y N</p> <p>Drainage Y N</p> <p>Headaches Y N</p> <p>Infection Y N</p> <p>Congestion Y N</p> <p>Polyps Y N</p>	<p>Mouth:</p> <p>Sores on Tongue Y N</p> <p>Gums Swelling Y N</p> <p>Lumps/Growth Y N</p> <p>Eyes:</p> <p>Watery Y N</p> <p>Itching Y N</p> <p>Change in vision Y N</p> <p>Redness Y N</p> <p>Other _____</p> <p>Neurological:</p> <p>Tremors Y N</p> <p>Dizzy Spells Y N</p> <p>Numbness/Tingling Y N</p> <p>Headache Y N</p> <p>Other _____</p> <p>Endocrine:</p> <p>Excessive Thirst Y N</p> <p>Too Hot/Cold Y N</p> <p>Tired/Sluggish Y N</p> <p>Other _____</p> <p>Gastrointestinal:</p> <p>Abdominal Pain Y N</p> <p>Nausea/Vomiting Y N</p> <p>Indigestion/Heartburn Y N</p> <p>Night Time Cough Y N</p> <p>Other _____</p> <p>Cardiovascular:</p> <p>Chest Pain Y N</p> <p>High Blood Pressure Y N</p> <p>Varicose Veins Y N</p>	<p>Skin:</p> <p>Skin Rash Y N</p> <p>Boils Y N</p> <p>Persistent Itch Y N</p> <p>Other _____</p> <p>Musculoskeletal:</p> <p>Joint pain Y N</p> <p>Neck pain Y N</p> <p>Back Pain Y N</p> <p>Other _____</p> <p>Respiratory:</p> <p>Wheezing Y N</p> <p>Frequent Cough Y N</p> <p>Shortness of Breath Y N</p> <p>Other _____</p> <p>Hematological/Lymphatic:</p> <p>Swollen Glands Y N</p> <p>Blood Clotting Problem Y N</p> <p>Other _____</p> <p>Psychological/Emotional:</p> <p>Depression Y N</p> <p>Anxiety Y N</p> <p>Medication Y N</p> <p>Other _____</p> <p>Allergic/Immunological:</p> <p>Hay Fever Y N</p> <p>Drug Allergies Y N</p> <p>Food Allergies Y N</p> <p>Hives Y N</p> <p>Behavioral Problems Y N</p> <p>Other _____</p>
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Practitioner Signature

Date