

Today's Date \_\_\_\_\_

**PATIENT NAME:** Please print (If you need help filling out this form let our receptionist know)

\_\_\_\_\_  
(First) (M) (Last) Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_

Name of your regular Physician (s) \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**I. PAST MEDICAL HISTORY**

• Current or past illness \_\_\_\_\_ [ ] None  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Do you have any allergies?  
To medications (Please List) \_\_\_\_\_ [ ] Yes [ ] No  
\_\_\_\_\_  
\_\_\_\_\_

Others (Hayfever, foods, latex) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Have you ever had surgery? (Please List) \_\_\_\_\_ [ ] No  
Date \_\_\_\_\_  
Date \_\_\_\_\_  
Date \_\_\_\_\_

• Have you ever had problems with anesthesia? \_\_\_\_\_ [ ] Yes [ ] No  
Type of reaction \_\_\_\_\_

• Have you or family members had a blood clotting or bruising problem? \_\_\_\_\_ [ ] Yes [ ] No

• **MEDICATIONS**

Current prescription drugs \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over the counter drugs \_\_\_\_\_  
(aspirin, nose spray) \_\_\_\_\_  
or herbal medications \_\_\_\_\_  
(i.e., Gingko, St. John's Wort) \_\_\_\_\_  
\_\_\_\_\_

• Are you pregnant? \_\_\_\_\_ [ ] Yes [ ] No

**PLEASE SEE OTHER SIDE**

II. REVIEW OF SYSTEMS - Circle either "no problems" or the individual problems for each area.

<u>ENT</u>	<u>Constitutional</u>	<u>Heart</u>	<u>Lungs</u>	<u>Digestive</u>
No Problems	No Problems	No Problems	No Problems	No Problems
Ear Pain	Weight Loss	High Blood Pressure	Shortness Breath	Heart Burn
Hearing Loss	Night Sweats	Heart Attack	Chronic Cough	Ulcers
Dizziness	Fever	Chest Pains	Asthma/Wheezing	Hepatitis
Nasal Congestion	Fatigue	Palpitations	Emphysema	Liver Disease
Sore Throat		Murmur	TB (Tuberculosis)	Swallowing Problems
Hoarseness				
Lump in Neck				

<u>Neurologic</u>	<u>Endocrine</u>	<u>Skin</u>	<u>Eyes</u>	<u>Blood</u>
No Problems	No Problems	No Problems	No Problems	No Problems
Seizures	Thyroid Disease	Skin Cancer	Blindness	Anemia
Strokes	Diabetes	Hives	Double Vision	Abnormal Clotting
Headaches		Itching	Eye Pain	Leukemia/Lymphoma
Weakness			Abnormal Tearing	
Numbness				
MS (Multiple Sclerosis)				

• OTHERS

- Cancer (type) \_\_\_\_\_ [ ] Yes [ ] No
- Arthritis \_\_\_\_\_ [ ] Yes [ ] No
- Chemical Dependency (type) \_\_\_\_\_ [ ] Yes [ ] No
- Infection requiring hospitalization? \_\_\_\_\_ [ ] Yes [ ] No
- Injury requiring hospitalization \_\_\_\_\_ [ ] Yes [ ] No
- Have you ever had a blood transfusion? [ ] Yes [ ] No
- Have you ever been tested for HIV? [ ] Yes [ ] No

III. SOCIAL AND FAMILY HISTORY

- Occupation \_\_\_\_\_ [ ] Married [ ] Single [ ] Divorced
- Do you smoke? [ ] Yes [ ] No  
Packs per day \_\_\_\_\_ for \_\_\_\_\_ years?  
If you quit, how many years ago? \_\_\_\_\_
- Other types of tobacco? [ ] Pipe [ ] Cigars [ ] Chew
- Alcohol use - number of drinks per week. \_\_\_\_\_
- Do you use recreational drugs? [ ] Yes [ ] No
- Health conditions in your family including cancer, heart disease, diabetes (please list)

Physicians use only: Date & Initial: \_\_\_\_\_  Anti-smoking education reviewed

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