MEDICAL INFORMATION

Date:____________________

Name:____ Age:_____________ DOB:_________________

PAST MEDICAL HISTORY

Please check off illnesses or conditions ***you*** have had:

☐ Diabetes	☐ Glaucoma	☐ Heart Trouble	☐ Cancer	☐ High Blood Pressure
☐ Hepatitis	☐ HIV	☐ Vein Trouble	☐ Nervousness	☐ Asthma
☐ Ulcers	☐ Bleeding Tendency	☐ Jaundice	☐ Gonorrhea	☐ Tuberculosis
☐ Syphilis	☐ Rheumatic Fever	☐ Kidney Disease	☐ Emphysema	☐ Pneumonia
☐ Sinusitis	☐ Substance Abuse	☐ Urinary Tract Infection		

☐ Other____

____

____

PAST SURGICAL HISTORY

Please list and date any surgeries ***you*** have had?

☐ Tonsillectomy________________	☐ Adenoidectomy____________	☐ Ventilation Tube Placement_____________
☐ Sinus Surgery________________	☐ Ear Surgery_______________	☐ Other_________________________________

____

____

MEDICATIONS

Please list **current** medications ____

____

____

____

ALLERGIES

Have **you** had allergy to medicine or other substances?_____________

List____

SOCIAL HISTORY

☐ Married ☐ Single ☐ Live alone ☐ Live with family ☐ Employed ____________________________ ☐ Retired

Do you use tobacco?_______ In the past?_______ Type and daily amount?___________________ How long?_________

Do you use alcoholic beverages?_________ Type?_____________ Weekly amount?__________ How long?_________

FAMILY HISTORY

Please check off illnesses which have occurred in any of ***your blood relatives***:

☐ Diabetes	☐ Cancer	☐ Bleeding Tendency	☐ Kidney Disease
☐ Heart Disease	☐ Stroke	☐ High Blood Pressure	☐ Nervous Illness
☐ Tuberculosis	☐ Allergy	☐ Anesthesia Problems	☐ Asthma

☐ Other____

Causes of death of immediate family____

Reviewed by Dr. ____ Date: ________________________

REVIEW OF SYSTEMS

Name:____ **Date**:____________________

Please circle any of the following symptoms which ***you*** currently or recently experienced. If none apply, please check the box at the right.

Eyes: Visual disturbances, use of glasses or contacts, pain, redness, excessive tearing, double vision, glaucoma and cataracts. **None** ☐

Ears: Hearing loss, use of hearing aids, ringing in your ears, dizziness, ear drainage, ear fullness (clogged sensation), ear popping, ear ache. **None** ☐

Nose, Mouth & Throat Frequent colds, nasal stuffiness, inability to smell, hay fever, nosebleeds, sinus trouble, facial pain. Bleeding gums, sore throat, frequent sore throats, heartburn, hoarseness, snoring, difficulty or pain swallowing. **None** ☐

Respiratory: Cough, sputum, coughing up blood, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, pleurisy. **None** ☐

Gastro/ Intestinal: Trouble swallowing, heartburn, nausea, vomiting, indigestion, diarrhea, constipation, Rectal bleeding, abdominal pain, jaundice, hepatitis. **None** ☐

Genito/ Urinary : Hernia, sexual difficulty, abnormal menstruation, venereal disease, problems with Urination, incontinence, urinary infection, stones. **None** ☐

Musculo/ Skeletal: Joint pain, stiffness, arthritis, gout, backache, muscle pains, cramps. **None** ☐

Skin: Rashes, lumps, itching, dryness, color change, changes in hair or nails. **None** ☐

Cardio: Heart trouble, high blood pressure, murmurs, chest pain, palpitations. **None** ☐

Neurologic: Fainting, blackouts, seizures, paralysis, facial paralysis, local weakness, numbness, tingling, tremors, memory problems. **None** ☐

Psychiatric: Nervousness, anxiety, tension, rapid mood swings, depression. **None** ☐

Endocrine: Thyroid trouble, heat or cold intolerance, excessive sweating, diabetes, excessive thirst, hunger or urination. **None** ☐

Hematologic: Anemia, easy bruising or bleeding, past transfusions, and possible transfusion reactions. **None** ☐

Allergies/ Immunologic: Eczema, hives, runny nose, hay fever, insect hypersensitivity, food allergies. **None** ☐

Reviewed by Dr. ____ **Date**:________________

NAME: ____ **DATE:** ___________________________

CURRENT HEALTH STATUS:

What is the primary reason for this visit? ____

Date symptoms first occurred or injury happened: ____

If injury, where did the accident occur? ____

What symptoms are you having? (Swelling, pain, etc.) ____________________________________

Have you been treated for this problem by another doctor? __________________________________

Did you treat this yourself? (Advil, Aspirin, etc.) ____

What kind of treatment was done? ____

Have you ever injured this area before? _____________ If so, when? _________________________

Signature: ___________________________________ Date: ______________________________