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 ☐ Psychiatric ☐ Asthma
☐ Ulcers ☐ Bleeding Tendency ☐ Jaundice ☐ Gonorrhea ☐ Tuberculosis
☐ Syphilis ☐ Rheumatic Fever ☐ Kidney Disease ☐ Emphysema ☐ Pneumonia
☐ Sinusitis ☐ Substance Abuse ☐ Thyroid Disease ☐ Eyeglasses/Contacts ☐ Hearing Aids
☐ 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_______ ☐ Biopsy in Head & Neck Area ___________
☐ Pacemaker _______________ ☐ Defibrillator ____________ ☐ Spinal Implant _______________________
☐ 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
☐ Thyroid Cancer ☐ 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.

Ears:	Ear pain, drainage, change in hearing, ringing, dizziness, imbalance, ear infections, hearing loss, use of hearing aids, ear fullness(clogged ears), ear popping, earache. **None** ❒
Nose:	Runny nose, stuffiness, bloody nose, nasal obstruction, sinusitis, altered sense of smell. **None** ❒
Throat:	Hoarseness, sore throat, difficulty swallowing, voice changes, post nasal drainage, snoring, infections, dentures, bridges, implants, **None** ❒
Allergy:	Hives, nasal congestion, itchy nose, itchy eyes, sneezing, headaches, fatigue. **None** ❒
Respiratory:	Coughing blood, pain with breathing, shortness of breath, wheezing, productive cough. **None** ❒
Cardiac/Heart:	Chest pain, rapid/irregular heartbeats. **None** ❒
Gastro/ Intestinal:	Appetite/weight change, blood in stool, bowel problems, canker sores, diarrhea, heartburn. **None** ❒
Gastro/Urinary:	Difficulty urinating, frequent urination. **None** ❒
Constitutional:	Fatigue, fever, night sweats, weight gain/loss. **None** ❒
Endocrine:	Changes in growth, hair changes, heat/cold intolerance, excessive thirst. **None** ❒
Eyes:	Blurred vision, double vision, visual disturbances, use of glasses or contacts, pain, redness, excessive tearing, glaucoma, cataracts. **None** ❒
Neurologic:	Clumsiness, convulsions, headaches, memory problems, migraine, numbness, seizures, fainting, blackouts, paralysis, facial paralysis, local weakness, tingling, tremors. **None** ❒
Skin:	Skin growths/moles, ulcers, slow healing wounds, very dry skin. **None** ❒
Hematologic:	Anemia, bleed easily, bruise easily, joint pain, lymph node swelling. **None** ❒
Psychiatric:	Depression, hallucinations, mood changes, sleep disturbance, stress. **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: ______________________________