

Patient Name: _____ Account # _____ DOB: ____ / ____ / ____

What are your concerns for Today's visit?:

Please list any ALLERGIES to MEDICATIONS:

Past Medical History:	
1) Please check the "yes" or "No" box to indicate if you have any of the following illnesses	
For "yes" answers please explain:	
	Yes or No If Yes, Explain:
Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Heart Disease/Chol problem	<input type="checkbox"/> <input type="checkbox"/>
Hypertension(high BP)	<input type="checkbox"/> <input type="checkbox"/>
Respiratory/Lung problems	<input type="checkbox"/> <input type="checkbox"/>
Stomach or intestinal	<input type="checkbox"/> <input type="checkbox"/>
Kidney problems	<input type="checkbox"/> <input type="checkbox"/>
Hepatitis or HIV	<input type="checkbox"/> <input type="checkbox"/>
Allergy problems/therapy	<input type="checkbox"/> <input type="checkbox"/>
Thyroid problems	<input type="checkbox"/> <input type="checkbox"/>
Radiation to head and neck	<input type="checkbox"/> <input type="checkbox"/>
Facial trauma	<input type="checkbox"/> <input type="checkbox"/>
Anesthesia problems	<input type="checkbox"/> <input type="checkbox"/>
Other Medical Diagnosis	<input type="checkbox"/> <input type="checkbox"/>
2) Please list any operations (and dates) you have ever had (including tonsils & adenoids)	
3) Please list any current medications (and amounts, times per day):	
(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC meds)	
Social History:	
Do you smoke? List how much	<input type="checkbox"/> <input type="checkbox"/>
if no, did you smoke previously	<input type="checkbox"/> <input type="checkbox"/>
How often do you drink alcohol	_____
What is your occupation?	_____
Family History:	
Please check the "yes" or "No" box to indicate whether any relative have any of the following illnesses:	
If yes, please indicate which relative(s) have the problem:	
	Yes or No If yes, which relative:
Hearing problems	<input type="checkbox"/> <input type="checkbox"/>
Cancer	<input type="checkbox"/> <input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/> <input type="checkbox"/>
Heart problems	<input type="checkbox"/> <input type="checkbox"/>
Reviewed by: _____	

Date: ___/___/___

Patient Name: _____

DOB: _____

Review of Systems:

1) Please check "yes" or "No" box to indicate whether you presently have any of the following symptoms:

2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for your visit today

		Yes or No		Current		Yes or No		Current
ALLERGY	sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	enviromental allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	ear pain or itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	sense of smell problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	prob, snoring, apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat dryness/itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	dental problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TMJ problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIR	cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES	eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	watery or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	decreased visual fields	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEURO	headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	passing out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENERAL	chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>
ENDO	feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEMELYM	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sweating at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OB/GYN	pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MSK	joint aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	skin or hair changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH	depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anxiety or panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Stop Here

Reviewed by: _____