

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**ALLERGIES?**

Medication Allergies	Type of Reaction	Type of Reaction

Have you ever had an allergy test?  Yes  No  
 Have you ever taken allergy shots?  Yes  No  
 If yes, are you still taking them?  Yes  No      How much relief from shots?  minimal  partial  significant

**LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal)  None**

Medication	Dosage	How often taken	Medication	Dosage	How often taken

\*\*\*\* PHARMACY NAME (include address if known) \_\_\_\_\_

**MEDICAL / SURGICAL HISTORY: HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?**

<b>Cardiovascular:</b>	<u>Surgery/Management</u>	<b>Immunologic:</b>	<u>Surgery/Management</u>
Coronary Artery Disease	<input type="checkbox"/> Yes _____	Allergies Type: _____	<input type="checkbox"/> Yes _____
Elevated cholesterol (hyperlipidemia)	<input type="checkbox"/> Yes _____	Food Allergies Type: _____	<input type="checkbox"/> Yes _____
High Blood Pressure (hypertension)	<input type="checkbox"/> Yes _____	HIV / AIDS	<input type="checkbox"/> Yes _____
<b>Gastrointestinal:</b>		<b>Infectious Disease:</b>	
Hepatitis	<input type="checkbox"/> Yes _____	Mononucleosis	<input type="checkbox"/> Yes _____
Hernia	<input type="checkbox"/> Yes _____	STD Type: _____	<input type="checkbox"/> Yes _____
Gastroesophageal Reflux	<input type="checkbox"/> Yes _____	<b>Metabolic/endocrine:</b>	
<b>Genitourinary:</b>		Diabetes Type: _____	<input type="checkbox"/> Yes _____
Prostate enlargement (Prostatitis)	<input type="checkbox"/> Yes _____	Thyroid deficiency (hypothyroidism)	<input type="checkbox"/> Yes _____
Kidney Stones (Nephrolithiasis)	<input type="checkbox"/> Yes _____	Thyroid excess (hyperthyroidism)	<input type="checkbox"/> Yes _____
Renal Failure (acute)	<input type="checkbox"/> Yes _____	<b>Neoplastic:</b>	
<b>Ear / Nose / Throat: (HEENT)</b>		Cancer Type: _____	<input type="checkbox"/> Yes _____
Cataracts	<input type="checkbox"/> Yes _____	<b>Neurologic:</b>	
Glaucoma	<input type="checkbox"/> Yes _____	Migraine	<input type="checkbox"/> Yes _____
Chronic ear infections (otitis media)	<input type="checkbox"/> Yes _____	<b>Obstetric:</b>	
Hearing loss	<input type="checkbox"/> Yes _____	Pregnancy Date(s): _____	<input type="checkbox"/> Yes _____
Sinus problems (chronic sinusitis)	<input type="checkbox"/> Yes _____	<b>Psychiatric:</b>	
Nasal polyps	<input type="checkbox"/> Yes _____	Anxiety (adjustment disorder)	<input type="checkbox"/> Yes _____
Nasal allergies	<input type="checkbox"/> Yes _____	Depression (major)	<input type="checkbox"/> Yes _____
Recurrent tonsillitis	<input type="checkbox"/> Yes _____	<b>Pulmonary:</b>	
Tinnitus	<input type="checkbox"/> Yes _____	Asthma	<input type="checkbox"/> Yes _____
Vertigo	<input type="checkbox"/> Yes _____	COPD/Emphysema	<input type="checkbox"/> Yes _____
<b>Hematologic :</b>		Sleep Apnea	<input type="checkbox"/> Yes _____
Anemia	<input type="checkbox"/> Yes _____	Tuberculosis	<input type="checkbox"/> Yes _____

If YES to any of the above Diagnosis was surgery performed?

What \_\_\_\_\_ Where/When \_\_\_\_\_ By Who \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**FAMILY HISTORY:**

- |                               |                              |                          |                              |
|-------------------------------|------------------------------|--------------------------|------------------------------|
| ADD/ADHD                      | <input type="checkbox"/> Yes | Hearing deficiency       | <input type="checkbox"/> Yes |
| Alcoholism                    | <input type="checkbox"/> Yes | Hyperlipidemia           | <input type="checkbox"/> Yes |
| Allergies                     | <input type="checkbox"/> Yes | Hypertension             | <input type="checkbox"/> Yes |
| Alzheimer's Disease           | <input type="checkbox"/> Yes | Irritable Bowel Syndrome | <input type="checkbox"/> Yes |
| Asthma                        | <input type="checkbox"/> Yes | Learning disability      | <input type="checkbox"/> Yes |
| Blood disease                 | <input type="checkbox"/> Yes | Mental illness           | <input type="checkbox"/> Yes |
| CAD (Coronary Artery Disease) | <input type="checkbox"/> Yes | Migraines                | <input type="checkbox"/> Yes |
| CAD-Premature                 | <input type="checkbox"/> Yes | Obesity                  | <input type="checkbox"/> Yes |
| Cancer Type: _____            | <input type="checkbox"/> Yes | Osteoarthritis           | <input type="checkbox"/> Yes |
| CVA (Stroke)                  | <input type="checkbox"/> Yes | Osteoporosis             | <input type="checkbox"/> Yes |
| Depression                    | <input type="checkbox"/> Yes | PVD                      | <input type="checkbox"/> Yes |
| Developmental delay           | <input type="checkbox"/> Yes | Renal disease            | <input type="checkbox"/> Yes |
| Diabetes                      | <input type="checkbox"/> Yes | Seizure disorder         | <input type="checkbox"/> Yes |
| Eczema                        | <input type="checkbox"/> Yes | Other: _____             |                              |

**SOCIAL HISTORY:**

Tobacco Use?  Yes  No  Former

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol?  Yes  No  Former

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke?  Yes  No

Caffeine Consumption?  Yes  No Type: \_\_\_\_\_ Amount per day? \_\_\_\_\_

**REVIEW OF SYSTEMS: Check any of the following problems you have recently had:**

**General health problems**

- fatigue  fever  night sweats  unintentional weight loss  sleeping problems  weight gain

**Eye problems**

- double vision  itchy eyes  swelling  redness

**Ear problems**

- ear drainage  hearing loss  ear infections  dizziness  itchy  noise exposure  ringing /noise in ears  ear pain  tinnitus

**Nose & Sinus problems**

- chronic congestion  mouth breathing  nosebleeds  frequent sneezing  runny nose  post-nasal drip

**Mouth & Throat problems**

- difficulty swallowing  snoring  sore throat  hoarseness  sores in mouth  ulcers

**Heart or circulation problems**

- heart murmur  leg cramping  swelling of ankles  chest pain  blacking out  irregular heartbeat

**Lung or respiratory problems**

- shortness of breath  wheezing  cough

**Stomach problems**

- abdominal pain  diarrhea  heartburn  nausea  vomiting

**Brain or Nervous system problems**

- headache  seizures  weakness  numbness  facial pain

**Glands & Hormone problems**

- intolerance to heat  increased appetite  neck enlargement  intolerance to cold

**Blood or Lymph nodes problems**

- bleeds excessively after injury  bruises easily

**Allergy problems**

- food intolerances  insect bites

**Skin**

- rash  itchy  latex allergies  swelling  urticaria / hives

What is the reason you are here today? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_