Patient History Form

PLEASE BE AS COMPLETE AS POSSIBLE WHEN FILLING OUT THIS FORM.
Name:
Age:
PCP & Referring Physician's Name and Address, if known:
____
____

What brings you to our office today? (**Chief Complaint**):________________________
____
____

Past History(medical problems): PLEASE CIRCLE Y or N for all items:

Heart Disease	Y	N	Anxiety Disorder	Y	N
Lung Disease or Asthma	Y	N	Panic Attacks	Y	N
Deep Vein Thrombosis	Y	N	Depression	Y	N
High Blood Pressure	Y	N	Head and Neck Cancer	Y	N
Nasal Allergies	Y	N	Other Cancer	Y	N
Stroke or TIA	Y	N	Head Trauma	Y	N
Diabetes	Y	N	Seizures	Y	N
Thyroid Problems	Y	N	Bleeding Disorders	Y	N
GERD/Reflux	Y	N	Other Blood disorder	Y	N
Kidney Problems	Y	N	Arthritis	Y	N
Hepatitis/Liver Disease	Y	N	Nasal Allergies	Y	N

Other:____

Have you had any of the following **surgeries**? PLEASE CIRCLE Y or N for all items:

Tonsillectomy/Adenoidectomy	Y	N	Facial Plastic Surgery	Y	N
Head and Neck Surgery	Y	N	Spine Surgery	Y	N
Thyroid Surgery	Y	N	Sinus/Nasal Surgery	Y	N
Ear Surgery	Y	N	Sleep Apnea Surgery	Y	N

Other Surgical History:____

Have you ever had a bad reaction to Anesthesia? Y N

Are you currently taking Aspirin, ibuprofen or other NSAIDS daily? Y N

Are you taking any herbal or natural medicines? Y N If Yes, list____________________

Are you allergic to any medications? Y N If Yes, list____________________

Continued on other side

Family History - Circle any of the following diseases that run in your family:

Diabetes	Mother	Father	Sister/brother	Grandparent
Heart Disease	Mother	Father	Sister/brother	Grandparent
High Blood Pressure	Mother	Father	Sister/brother	Grandparent
Head and Neck Cancer	Mother	Father	Sister/brother	Grandparent
Cancer (Other :___________)	Mother	Father	Sister/brother	Grandparent
Easy bruising or bleeding	Mother	Father	Sister/brother	Grandparent

Other Diseases that run in your immediate family: ___________________________________
____

Social History

Do you use tobacco products now or have you in the past? Y N
If cigarettes, how many packs per day________
Number of Years you have/had smoked _______
If no longer smoking, how long ago did you quit? ___________________

Do you drink alcohol? Y N
If yes, how many drinks per day? _______ or per week?_______

What is your current or former occupation? ____________________________________

Review of Systems
Please CIRCLE Y or N for the symptoms that you may have **currently** or **recently** experienced:

Unexplained weight loss	Y	N	Fevers/Night sweats	Y	N
Change in Vision	Y	N	Heat/Cold Intolerance	Y	N
Dizziness	Y	N	Shortness of breath	Y	N
Chest Pain	Y	N	Bleeding/bruising easily	Y	N
Diarrhea	Y	N	Constipation	Y	N
Muscle or joint pain	Y	N	Trouble Swallowing	Y	N
Kidney/bladder problems	Y	N	Headaches	Y	N
Weakness or fatigue	Y	N	Numbness of face/hands/feet	Y	N

Other:____

Thank you for taking the time to fill out this form. I realize that we have a lot of paperwork for you and your help is greatly appreciated.

Patient's or Guardian's Signature: __________________________________Date:_____________

Confirmed by:
Physician's Signature:____Date:_____________