

NAME: _____ DATE: _____

WHAT BRINGS YOU TO OUR OFFICE TODAY?

WHAT ARE YOUR CURRENT OR PAST MEDICAL PROBLEMS?

PAST SURGERIES (list surgery and approximate date)

CURRENT MEDICATIONS (prescription, herbal, OTC meds)

ALLERGIES TO MEDICATIONS? (list medication, reaction)

FAMILY HISTORY (check all that apply)

- Hearing Loss
- Allergies
- Asthma
- Cancer
- Thyroid Disease
- Other Health Problems (list)

SOCIAL HISTORY

Have you ever used tobacco? Yes No quit date _____

Amount: _____ packs/day for _____ years

Type: _____ Cigarettes _____ Chewing tobacco

Do you drink alcohol? Yes No

Amount: _____ drinks per day/week/month

Do you drink caffeinated beverages? Yes No

Amount: _____ cups or cans a day

Type: coffee soda tea

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? (check all conditions that apply)

Constitutional

- Fever
- Pain
- Weight loss/gain

Neurological

- Headaches
- Weakness
- Numbness

Eyes

- Itching dryness
- Excessive tearing

Ears, Nose, Mouth, Throat

- Hearing loss
- Nasal obstruction
- Runny nose
- Nosebleeds
- Snoring
- Sore throat
- Lump in neck

Cardiovascular

- Chest pain
- Shortness of breath
- Palpitations

Respiratory

- Cough
- Hoarseness
- Wheezing
- Noisy breathing

Gastrointestinal

- Heartburn
- Throat clearing

Musculoskeletal

- Muscle pain
- Joint pain

Skin

- Rash
- Acne
- Change in moles

Endocrine

- Cold/Heat intolerance
- Night sweats

Allergic/Immunologic

- Sneezing
- Frequent infections