Patient History

Ethnicity _____ Race _____

Date: _____

Name: _____

Date of Birth: _____

Spouse/Parent Name: _____

Reason for visit: _____

PAST MEDICAL HISTORY

Medical	Date	Surgeries
___Anesthesia		___Abdominal
___Arthritis		___Breast
___Asthma		___Broken Bones
___Bleeding Disorder		___Cosmetic
___Blood Transfusion		___Heart/ Lung
___Cancer		___Prostate
___Depression		___Uterus and/or Ovary
___Diabetes		___Ears
___Lung Disease		___Neck
___Epilepsy		___Nose
___Heart Disease		___Sinus
___Hepatitis		___Throat
___High Blood Pressure		___Thyroid
___Jaundice		___Other
___Migraine		_____
___Prostate Problems		_____
___Rheumatic Fever		___Radiation Treatment or Exposure
___Thyroid Trouble		_____
___Tuberculosis		___Chemotherapy
___Venereal Disease		_____
___Other(specify) _____		_____

Injuries	Dates
___Facial Fracture	_____
___Nasal Fracture	_____
___Other Fractures	_____
___Concussion	_____

MEDICATIONS DOSE FREQUENCY

_____
_____
_____
_____

LIST ALL DRUG ALLERGIES/SENSITIVITIES

___Codeine
___Penicillin
___Sulfa
___Others

_____
_____
_____

If yes, explain reaction: _____

_____
_____

Family History

___Diabetes	___Blood Disorders
___Heart Disease	___Stroke
___Anesthesia Reactions	___Other
___Cancer	_____
	_____

SOCIAL HISTORY (PLEASE CIRCLE)

Single Married Widowed Divorced Separated
Children: None 1 2 3 4 5 6 other _____
Occupation: _____
Do you presently smoke?_____ #per day_____# of years _____
If NO, have you ever smoked?_____#of years _____#per day___
Drink caffeinated beverages _____ #per day_____
Do you drink alcohol? _____ type of alcohol _____
Drinks per day/week/month??_____
Recreational Drug Use? _____

SYSTEM REVIEW

Eyes
___Loss of Vision
___Double Vision
___Blurriness
___Pain

Cardio respiratory
___Chest Pain
___ Difficulty Breathing
___Cough
___Wheezing
___Short of Breath
___Abnormal Check X-ray
___Irregular Heartbeat

Gastrointestinal
___Appetite
___Weight Loss/Gain
___Swallowing
___Indigestion
___Heartburn
___Ulcer
___Vomiting
___Pain
___Bowel Changes
___Rectal Bleeding

Geniourinary (Urinating)
___Difficult
___Pain/Burning
___Blood
___Incontinence
___Frequency

Gynecologic
___Pre-Post Menopausal
___Last Menstrual Period
___Abnormal Bleeding
___Attempting Pregnancy
___Last Pap Smear
___Last Mammogram

Musculoskeletal
___Joint Pain
___Swelling

Neurologic
___Headache
___Weakness
___Loss of Movement
___Black Outs
___Fainting
___Psychiatric Problems
___Seizure
___Numbness

Skin
___Bruising
___Rashes
___Itching
___

Ears
___Pain
___Drainage
___Hearing Loss
___Ringing
___Dizziness
___Infections

Nose
___Obstruction
___Smell
___Drainage
___Bleeding
___Pain
___Sinusitis

Throat
___Pain
___Bad Breath
___Hoarsness
___Post-Nasal Drip
___Difficulty Swallowing
___Dental Problems
___Tonsillitis
___Snoring

Neck
___Pain
___Swollen Glands
___Limited Range of Motion
___Thyroid Problems

Physician Signature:_____