Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Please mark all symptoms that you are experiencing TODAY!
Mark all that apply. If no symptoms in a category, please mark **"NONE."**

GENERAL	fatigue ○	fever ○	weight loss ○	**NONE** ○
SKIN	rash ○	hives ○	new lesions ○	**NONE** ○
HEAD AND NECK	nasal congestion ○ nose bleed ○ runny nose ○ sneezing ○	ear pain ○ vertigo ○ hearing loss ○ ringing in the ears ○	eye pain ○ sore throat ○ swollen glands ○ neck mass ○ mouth sores ○	**NONE** ○
RESPIRATORY		cough ○	snoring ○	**NONE** ○
CARDIOVASCULAR	chest pain ○	palpitations ○	shortness of breath ○	**NONE** ○
GASTROINTESTINAL		difficulty swallowing ○	heartburn ○	**NONE** ○
MUSCULOSKELETAL		joint pain ○	muscle ache ○	**NONE** ○
NEUROLOGICAL	dizziness ○	headaches ○	fainting ○	**NONE** ○
PSYCHIATRIC	anxiety ○	depression ○	insomnia ○	**NONE** ○
ENDOCRINE		appetite changes ○	thyroid problems ○	**NONE** ○
HEMATOLOGY	easy bruising ○	enlarged lymph nodes ○	abnormal bleeding ○	**NONE** ○

TOBACCO USE

What is your smoking status?	current (every day) ○	current (some days) ○	previous ○	never ○
Do you use chewing tobacco?	current (every day) ○	current (some days) ○	previous ○	never ○
Are you exposed to passive (secondhand) smoke?		yes (outdoors only) ○	yes ○	no ○

ALCOHOL USE

Do you drink alcohol?	daily ○	occasionally ○	previous ○	never ○

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following (mark all that apply)**:**

- ○ Asthma
- ○ Autoimmune Disease
- ○ Bleeding Disorders
- ○ Cancer
- ○ Diabetes
- ○ Difficulty with Intubation (tube insertion)
- ○ Hearing Loss
- ○ Heart Problems
- ○ High Blood Pressure
- ○ HIV Positive
- ○ Kidney Disease
- ○ Liver Disease
- ○ Lung Disorder
- ○ Neurological Disorder
- ○ Psychiatric Problems
- ○ Sleep Apnea
- ○ Stroke
- ○ Thyroid Disease
- ○ **NONE**

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SURGICAL HISTORY

Please indicate if YOU have had any of the following surgeries.

(If you have had additional surgeries that you want us to be aware of, please discuss with the physician during your visit.)

- ◯ Adenoids Removed
- ◯ Brain Surgery
- ◯ Carotid Surgery
- ◯ Ear Surgery
- ◯ Ear Tubes
- ◯ Heart Surgery
- ◯ Hysterectomy
- ◯ Lung Surgery
- ◯ Neck / Spine Surgery
- ◯ Pacemaker
- ◯ Sinus Surgery
- ◯ Spleen Removed
- ◯ Thyroid Surgery
- ◯ Tonsillectomy
- ◯ **I HAVE HAD NO SURGERIES**

FAMILY MEDICAL HISTORY

Please indicate which family member(s) have had these illnesses:

	Father	Mother	Sibling	NONE
Difficulty with Anesthesia	◯	◯	◯	◯
Asthma	◯	◯	◯	◯
Bleeding Disorders	◯	◯	◯	◯
Cancer	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯
Hearing Loss	◯	◯	◯	◯
Lung Disease	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯
Thyroid Problems	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯

◯ **Family History UNKNOWN** ◯ **ADOPTED**

PEDIATRIC PATIENTS (ONLY complete if patient is 17 years old or younger)

Does the PATIENT have a history of the following (mark all that apply)**:**

- ◯ Developmental Delay
- ◯ Low Birth Weight
- ◯ Jaundice
- ◯ Newborn Hearing Screening Failed
- ◯ NICU (Neonatal Intensive Care Unit)
- ◯ **NONE**

MEDICATIONS

Please list all medications you are currently taking, or provide us with a copy of a list.

Include prescription medications, over the counter medications and herbal supplements (e.g., aspirin, vitamins, herbs, etc.):

Name	Dosage	Frequency