Chief Complaint and History of Present Illness

1. Please briefly describe the problem that brings you here today.

   _____
   _____
   _____
   _____

   _____
   _____
   _____
   _____

2. Please list all the medicine you are currently taking.

   _____
   _____
   _____
   _____

3. Please list any known allergies to drugs, food, inhalants or other substance.

   _____
   _____

4. Are you pregnant? □ Yes □ No □ Possibly

Patient Name_____

Date _____

Review of Systems

Please check the box next to any medical condition that you ***currently*** have

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue

Endocrine
- ☐ Weight loss
- ☐ Weight gain
- ☐ Intolerance to Heat
- ☐ Intolerance to Cold

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing up blood

Musculoskeletal
- ☐ Muscle aches
- ☐ Bone pain

Skin
- ☐ Rashes
- ☐ Itching
- ☐ Sores
- ☐ Skin Changes

Lymphatic/Hematologic
- ☐ Easy bruising
- ☐ Easy bleeding

Psychiatric
- ☐ Anxiety
- ☐ Depression

Eye
- ☐ Blurred Vision
- ☐ Itchy eyes
- ☐ Double vision
- ☐ Eye pain
- ☐ Dryness
- ☐ Tearing

Gastrointestinal
- ☐ Constipation
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Belching

Neurologic
- ☐ Seizures
- ☐ Headache

Allergic/Immunologic
- ☐ Sneezing
- ☐ Seasonal allergies

Ear, Nose & Throat
- ☐ Hearing loss
- ☐ Noise in ears
- ☐ Ear discharge
- ☐ Earache
- ☐ Itchy ears
- ☐ Dizziness
- ☐ Ear lesions
- ☐ Loss of Sense of smell
- ☐ Nosebleeds
- ☐ Nasal discharge
- ☐ Nasal congestion
- ☐ Post-nasal drip
- ☐ Nasal lesions/polyps
- ☐ Bleeding gums
- ☐ Oral sores
- ☐ Dry mouth
- ☐ Bad breath
- ☐ Loss of sense of taste
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Problems swallowing
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Lumps in neck
- ☐ Unclear speech
- ☐ Sinus infections

Genitourinary
- ☐ Painful urination
- ☐ Blood in urine

Cardiovascular
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Stroke

Patient Name_____
Date _____

Past Medical, Family and Social History

1. Please check the box next to any medical condition that you currently have or have had in the past

□ Asthma	□ G.I. Disease	□ Thyroid Disease
□ Kidney Disease	□ Depression	□ HIV/AIDS
□ Cancer	□ High Blood Pressure	□ E.N.T. Surgery
□ Diabetes	□ Heart Disease	□ Anemia
□ Hepatitis	□ Liver Disease/Jaundice	□ Hemophilia
□ Stroke	□ Chemical dependency	□ STI/STD

□ Bleeding Tendency/ Bleeding Disorder (easy bleeding or bruising)
□ Other _____

2. Please list any previous surgeries.
   _____
   _____

3. Do you have any medical restrictions do to your religion? □Yes □No

4. Is there a family history of hearing loss or vertigo problems? □Yes □ No

5. Is there a family history of bleeding disorder? □ Yes □ No

6. If yes, please list the name of the disorder _____

7. Have you ever smoked cigarettes, cigars, pipes or chewed tobacco?
   □Yes □ No

8. Do you smoke now? □Yes □ No

9. If you have stopped, how old were you when you stopped?
   _____

10. On average, how many packs per day have you smoked for the length of time you smoked? _____

11. How many packs per day do you smoke now?

12. Do you drink alcoholic beverages? □Yes □ No

13. If so, how often do you consume alcoholic beverages?

□ Monthly or less □ 2-4 times a month 2-3 times per week □ 4 or more times a week

14. How many alcoholic drinks do you have on a typical day when you are drinking?

□ 1-2 □ 3-4 □ 5-6 □ 7 or more

Patient Name_____
Date _____