Name: _____ **DOB:** _____

Date: _____ **Referred from:** _____

Age: _____ **Height:** _____ **Weight (lbs):**_____ **Sex: Male / Female**

CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit?_____
2. Have you sought legal advice for this problem? ❑ Yes ❑ No

BIRTH/PEDIATRIC HISTORY (FOR PEDIATRIC PATIENTS ONLY):

Hospital & Location:_____

Delivery: ❑ Normal vaginal ❑ C-section Weeks in gestation? ❑ Full term ____#weeks ❑ Premature _____#weeks

Multiple birth (please check if appropriate): ❑ twins ❑ triplets ❑ quadruplets ❑ quintuplets ❑ other: _____

Birth Weight: _____lbs or _____kg Immunizations:up to date ❑ Yes ❑ No

Complications of pregnancy?(please specify ay problems which medication was used for)

_____

Infant pass his hearing screen at hospital? ❑ **Yes** ❑ **No** Did the mother use prenatal care? ❑ **Yes** ❑ **No**

Any hospitalizations: ❑ Yes ❑ No if so, for how long _____ days/weeks/months Why? _____

Any treatments at birth: ❑ Yes ❑ No Please list _____

_____

Any history of intubation or needing to be connected to a breathing machine? ❑ Yes ❑ No How long? _____

History of jaundice requiring light therapy? ❑ Yes ❑ No Social or behavioral issues? _____

Academic/school issues? _____ Attends Daycare? ❑ yes ❑ no

PAST MEDICAL HISTORY

Neurologic
- ❑ Alzheimer's disease
- ❑ Multiple sclerosis
- ❑ Bell's palsy
- ❑ Stroke/mini-stroke
- ❑ Parkinson's disease
- ❑ Seizures
- ❑ Migraines
- ❑ Chronic headaches

Eyes/Ear/Nose/Throat
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Thyroid disease
- ❑ Laryngitis
- ❑ Recurrent tonsillitis
- ❑ Reflux
- ❑ Recurrent sinusitis
- ❑ Cholesteatoma
- ❑ Vasomotor rhinitis
- ❑ Otitis media/externa
- ❑ Allergic rhinitis
- ❑ Parotid swelling, recurrent
- ❑ Chronic cough
- ❑ Sleep apnea/snoring
- ❑ Otosclerosis
- ❑ Recurrent ear infections

Pulmonary/Cardiovascular
- ❑ High blood pressure
- ❑ Abnormal EKG/heart rhythm (_____)
- ❑ Heart aneurysm
- ❑ Carotid disease
- ❑ Coronary artery disease
- ❑ Asthma/Bronchitis
- ❑ Emphysema
- ❑ COPD
- ❑ Angina
- ❑ Heart disease
- ❑ Enlarged heart
- ❑ Peripheral vascular disease
- ❑ Valvular disease/murmur
  please specify _____
- ❑ Congestive heart failure (CHF)
- ❑ High/low cholesterol (circle one)
- ❑ Heart attack
- ❑ Pneumonia
- ❑ Chronic cough

Musculoskeletal
- ❑ Juvenile Rheumatoid arthritis
- ❑ Joint disease
- ❑ Gout
- ❑ Neck/back disease
- ❑ Autoimmune disease
- ❑ Carpal tunnel syndrome
- ❑ Anemia
- ❑ Frequent falls
- ❑ Juvenile Rheumatoid arthritis

Infectious Disease
- ❑ Sexually transmitted disease
  please specify _____
- ❑ Measles
- ❑ Mumps
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ AIDS
- ❑ Rubella
- ❑ Chicken pox
- ❑ Recurrent *Strep* infections

Endocrine/Psychiatric/Misc
- ❑ Diabetes- non-insulin dependent
- ❑ Diabetes – insulin-dependent
- ❑ Chronic fatigue
- ❑ Osteoporosis
- ❑ Schizophrenia
- ❑ Anxiety
- ❑ Attention Deficit Disorder
- ❑ Panic attacks
- ❑ Bipolar disorder
- ❑ Bleeding disorder
- ❑ Depression

Gastrointestinal/Genitourinary
- ❑ BPH
- ❑ Hiatal hernia
- ❑ Gall bladder disease
- ❑ Irritable bowel syndrome
- ❑ Kidney disease/stones
- ❑ Hepatitis (please specify _____)
- ❑ Peptic ulcer disease

❑ Cancer (including skin): _____

❑ Skin condition (i.e., vascular marking, rosacea, psoriasis, eczema): _____

❑ Other: _____

Any genetic syndrome: _____

Any spinal disorder: _____

❑ Smoke, second hand exposure ❑ Yes ❑ No

ALLERGIES (List medications/foods you are allergic to and what happens when you take them): ❑ None

a) Medication_____Reaction_____
b) Foods_____Reaction_____
c) Non Drug Allergies_____
d) Does your child have a history of anaphylaxis? ❑ Yes ❑ No
e) Does your child have an allergy to latex? ❑ Yes ❑ No
f) Does your child have a history of a transfusion reaction? ❑ Yes ❑ No

FAMILY HISTORY (Check all illnesses that run in your family): ❑ None

❑ Alcoholism ❑ Allergies/hayfever ❑ Alzheimer's Disease ❑ Anemia
❑ Anemia, Sickle cell ❑ Anxiety, Sickle cell ❑ Arthritis ❑ Asthma
❑ Breast Cancer ❑ Colon Polyps ❑ Colon/rectal Cancer ❑ COPD/ emphysema
❑ Coronary Artery Disease ❑ Crib death or SIDS ❑ Degenerative joint disease
❑ Depression ❑ Diabetes ❑ Gallbladder disease ❑ Hearingloss
❑ Heart attack(s) ❑ Kidney Stone ❑ Melanoma ❑ Mental Illness/Suicide
❑ High blood pressure ❑ High Cholesterol ❑Migraines
❑Osteoporosis ❑Other _____ ❑ Parkinson's Disease ❑ Poor Circulation
❑ Stroke ❑ Thyroid Cancer ❑ TIAs – Transient ischemic attacks
❑ Thyroid Disease (high-hyperthyroidism) ❑ Thyroid disease (low-hypothyroidism)

Syndrome, genetic (please specify) _____

Cancer (please Specify)_____

❑ Does not know family history, patient adopted

PAST SURGICAL HISTORY (Please check any surgeries you have had): ❑ None

❑ Adenoidectomy ❑ Aneurysm ❑ Appendectomy ❑ Back Surgery
❑ Carotid endarterectomy ❑ Cataract Excision ❑ Cholecystectomy
❑ Colon Surgery ❑ Colostomy ❑ Coronary artery bypass
❑ Ear surgery- ear drum repair (tympanoplasty) ❑ Ear Surgery – mastoid surgery (mastoidectomy)
❑ Brain surgery ❑ Tonsillectomy ❑ Rhinoplasty ❑ Septoplasty
❑ Sinus surgery ❑ Sinus surgery (please specify) _____
❑Thyroidectomy, total ❑ Tonsillectomy ❑ Tonsillectomy and adenoidectomy (T&A)
❑ Turbinate reduction ❑ P.E.T (ear tubes)
❑ Transplant (please specify, body part and when?) _____
Other _____
Describe any complications related to surgery: _____
_____
Describe any complications related to anesthesia: ❑ None ❑ Nausea ❑ Vomiting _____
_____

REVIEW OF SYSTEMS (**Check all symptoms you have had either now or in the past):**

CONSTITUTIONAL

❑ Weight loss_____pounds in the past ____weeks ❑ Fever, chills ❑ Night sweats ❑ **None**
❑ Fatigue ❑ Loss of appetite

EYES:

❑ Wears glasses ❑ Blurring of vision ❑ Redness ❑ Other: _____
❑ Wears contacts ❑ Swelling ❑ Itchy eyes
❑ Blindness ❑ Dryness of eyes ❑ Double vision
❑ Watery eyes ❑ Eye pain ❑ Discharge ❑ **None=**

ENT: ❑ **None** ❑ Other _____
❑ Allergies ❑ Ear pain ❑ Hearing loss ❑ Nosebleeds ❑ Snoring
❑ Bleeding gums ❑ Facial pain ❑ Heartburn ❑ Nose pain ❑ Sore throat
❑ Decreased/lost smell ❑ Gum disease ❑ Hoarseness ❑ Septal perforation ❑ Sores on lips/gums
❑ Dentures ❑ Facial pain ❑ Mouth sores ❑ Teeth problems ❑ Voice changes
❑ Difficulty swallowing ❑ Gum disease ❑ Nasal congestion ❑ Postnasal drip ❑ Throat pain
❑ Dizziness/vertigo ❑ Headaches ❑ Nasal discharge ❑ Rhinorrhea ❑ Bad breath/taste
❑ Ear drainage ❑ Hearing aids ❑ Nasal obstruction ❑ Ringing in ears/tinnitus

Name: _____

CARDIOVASCULAR:
❑ Shortness of breath (at rest) ❑ Palpitations ❑ None
❑ Shortness of breath (exertion) ❑ Chest pain/pressure ❑ Other:
_____

PULMONARY/RESPIRATORY
❑ Cough ❑ Coughing blood (hemoptysis) ❑ Shortness of breath
❑ **None** ❑ Other: _____

GASTROINTESTINAL:
❑ Abdominal pain ❑ Change in bowel habits ❑ Nausea and vomiting ❑ Diarrhea
❑ Vomiting blood (hematemsis) ❑ Use of antacids ❑ Blood in stool
❑ **None** ❑ Other: _____

GENITOURINARY:
❑ Blood in urine (hematuria) ❑ Hesitancy ❑ Nocturia ❑ Wets bed (enuresis)
❑ **None** ❑ Other: _____

MUSCULOSKELETAL:
❑ Back pain ❑ Neck pain ❑ Weakness ❑ **None** ❑ Other:
_____

SKIN:
❑ Acne ❑ Itching ❑ Birth marks ❑ Loss of hair ❑ Change in mole
❑ Skin rashes ❑ Dryness ❑ **None** ❑
Other:_____

NEUROLOGICAL:
❑ Memory loss ❑ Paralysis of arm or leg ❑ Speech difficulty ❑ Paresthesia
❑ Syncope ❑ Head trauma ❑ Near syncope ❑ Local weakness
❑ Numbness ❑ **None** ❑ Other:
_____

PSYCHIATRIC:
❑ Disturbing thoughts/feelings ❑ Suicidal thoughts ❑ Hallucinations ❑ **None** ❑ Other: _____

ENDOCRINE
❑ Heat or cold intolerance ❑ Thyroid nodule ❑ Hair loss ❑ Increased thirst
❑ **None** ❑ Other: _____

HEMATOLOGY/LYMPHATIC: ❑ Abnormal bleeding ❑ Easy bruising ❑ **None**
❑ Are you currently being anticoagulated? ❑ Yes ❑ No ❑ Enlarged lymph nodes

ALLERGY/IMMUNOLOGY
❑ Itchy eyes ❑ Red eyes ❑ Sneezing ❑ Hayfever
❑ Itchy nose ❑ Swollen eyes ❑ Urticaria ❑ Eye discharge
❑ Rashes ❑ **None** ❑ Other:
_____

DO YOU HAVE ANY IMPLANTABLE DEVICES? If so, what and where? _____

MEDICATIONS (List all your current medications and the dose you take): ❑ None (please use back if needed)
Medication_____Dose_____
Medication_____Dose_____
Medication_____Dose_____
Do you take Aspirin or Ibuprofen? ❑ Yes ❑ No
Do you take Warfarin (Coumadin) /Plavix ? ❑ Yes ❑ No Have you taken steroids within the past year? ❑ Yes ❑ No

Thank you for your cooperation