Patient Name: _____ Date: _____

HISTORY OF PRESENT ILLNESS

What is the main reason for today's visit?

◯ Ear ◯ Nose ◯ Throat ◯ Allergy ◯ Sleep ◯ Dizzy

How would you describe the problem?

_____

On a scale from 1 – 10 (10 being the worst), how would you rate your discomfort? _____

How long has this been going on? _____

Have you tried anything for this? (If so, what have you tried?)

_____

What makes it better? _____

What makes it worse? _____

Are there any other issues you would like to discuss today?

_____

Do you have any new medical conditions or medications since your last visit?

_____

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	◯ Yes	◯ No
Do you often feel tired, fatigued, or sleepy during the day?	◯ Yes	◯ No
Has anyone observed you stop breathing during sleep?	◯ Yes	◯ No
Do you have or are you being treated for high blood pressure?	◯ Yes	◯ No