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HEALTH INFORMATION, page 1

Today's Date: _______________

Patient Last Name: _________________________ Patient First Name: __________________________ Birth Date: __________ Height: ________ Weight: ________

DOCTOR WHO SENT YOU HERE: ____________________________________

1) WHAT IS THE REASON FOR TODAY'S VISIT? ____

2) PAST MEDICAL HISTORY (Click All That Apply)___

Heart Disease	Allergy/Hay Fever	Diabetes/Sugar	High Blood Pressure
Alcoholism	Thyroid Problem/Goiter	Mental Illness/Retardation	Arthritis
Depression	Irregular Heart Beat	Glaucoma	Migraines
Asthma/Bronchitis/Lung	Tuberculosis	Bleeding Disorder/Anemia	Urine/Kidney Disease
Stroke	AIDS/HIV	Lyme Disease	High Cholesterol
Epilepsy/Seizures	Liver Disease/Hepatitis	Reflux/Ulcer	Bone Fractures
Otosclerosis	Prostate	Menieres Disease	Deafness
Osteoporosis	Cancer — Where? _____________	Radiation Therapy?	Chemotherapy?

Other ____

3) PAST SURGICAL HISTORY

4) LIST YOUR CURRENT MEDICATIONS (prescription, over-the-counter, vitamins, herbals, aspirin, birth control, etc.):

5) DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR LATEX? ____

6) FAMILY HISTORY (Click All That Apply)

Heart Disease	Diabetes/Sugar	High Cholesterol	Arthritis
Blood Pressure	Anesthesia Problems	Thyroid Disease	Migraines
Lung Disease/Asthma	Hay Fever/Allergies	Bleeding Disorder	Anemia
Hearing Loss	Otosclerosis	Menieres Disease	Osteoporosis
Alcoholism	Cancer	Mental Illness	Epilepsy

7) SOCIAL HISTORY

Job Description or School Grade: ____

Do You Smoke? Packs a Day? ________ # of Years? ______ Did You Ever Smoke? When Did You Quit? ___________ Second-Hand Smoke?

How Many Cups of Caffeinated Beverages Per Day? (Coffee, Tea or Soda)? ___________________________

How Often & How Much Alcohol Do You Drink? ____

What Kind of Pets Do You Have? ____

Are You Single? Married? # Of Children _______ Vaccines Up-to-Date?

Are You Pregnant? PAP Smear Less Than 3 Years Ago? Types of Exercise: ______________________ Special Diet? : ________________________________

8) OTHER/COMMENTS

Patient Name: ____ DOB: _______________ Date: _______________

9) REVIEW OF SYSTEMS (Check all that apply)

General Symptoms	Fever	Night Sweats	Appetite Change
	Weight Change	Sleeping Problems	Born Prematurely
Eyes	Vision Changes	Eye Infections	Itchy/Watery
Ears	Decreased Hearing	Ear Infections (#/yr _____)	Ringing/Noises
	Ear Pain	Dizzy Spells/Vertigo	Hearing Aids
	Drainage/Odor	TMJ Disorder	Ear Wax
	Trouble Popping	Q-Tip Use	
Nose	Nosebleeds	Broken/Deviated Septum	Congested
	Sneezing/Allergies	Nasal Pain	Poor Sense of Smell
	Nasal Polyps	Sinus Infections (#/yr _____)	Post-Nasal Drip
Mouth/Throat	Sore Throat	Tonsil Infections (#/yr _____)	Vocal Cord Polyps
	Mouth Lesions	Hoarseness/Laryngitis	Speech Delay
	Dental Problems	Cleft Lip/Palate	Bad Breath
Cardiovascular	Chest Pain/Palpitations	Heart Murmur	Swollen Ankles
Respiratory	Chronic Cough	Wheezing	Increased Sputum
	Shortness of Breath	Snoring	Sleep Apnea/C-PAP
Gastrointestinal	Difficulty Swallowing	Heartburn	Nausea
	Vomiting	GI Bleeding	Change in Bowel Habits
Genitourinary	Frequent Urination	Urine Infections	Venereal Disease
	Prostate Problems	Menopause	Pregnancy Problems
	Breast Disease	Breast-feeding	
Musculoskeletal	Weakness	Joint Pain	Muscle Cramps
Skin	Rashes	Itching	Skin Lesions
Neuropsychiatric	Seizures	Tremor	Headaches
	Anxiety	Depression	Psychiatric Care
	Drug/ETOH Addiction	Increased Stress	
Endocrine	Heat/Cold Intolerance	Increased Thirst	
Hematological	Blood Transfusions	Bruise Easily	
Allergic/Immunologic	Seasonal	Food	Allergy Shots

Other Comments: ____