Shelley Berson, MD, FAASM, FAAOA Rockland Ear, Nose and Throat Associates, P.C.

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?

Anesthesia Problems: _____

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
☐ High 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

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Reviewed By:

Shelley Berson, MD, FAASM, FAAOA
Rockland Ear, Nose and Throat Associates, P.C.

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: _____

Reviewed by: _____