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Patient History Form

Patient Name: _____ DOB: _____/_____/_____ Male Female

Reason for Visit: _____

ALLERGIES: Please list **ALL** allergies, including any medications that cause allergic reactions

DRUG ALLERGIES: _____

_____

_____

ENVIRONMENTAL ALLERGIES:

❑ Dust ❑ Mold ❑ Animal ❑ Pollen ❑ Ragweed

❑ Latex ❑ Anesthesia ❑ Other (list):

MEDICATIONS: List **ALL** medications you are currently taking, including "over-the-counter" and supplemental

DRUG NAME (GENERIC/BRAND)	DOSAGE	FREQUENCY

MEDICAL HISTORY:

❑ Hearing Loss ❑ Heart Disease ❑ Diabetes ❑ Asthma ❑ Stroke

❑ Hypertension ❑ Seizure Disorder ❑ Cancer ❑ Kidney Disease ❑ Migraine

❑ Mental Illness ❑ Alcoholism ❑ Thyroid ❑ Other: _____

FAMILY HISTORY:

	Deceased	Cause of Death (Age)	Hearing Loss	Hyper-tension	Heart Disease	Seizure Disorder	Diabetes	Cancer	Asthma	Kidney Disease	Stroke	Migraine	Mental Illness	Alcoholism	Thyroid
Mother															
Father															
Brother															
Sister															

Other (please list): _____

Have you traveled recently? Yes No If so, when: _____ Where: _____

HOSPITAL ADMISSION/SURGICAL HISTORY: Please provide a complete history, including all illnesses, injuries, hospitalizations, and operations

OPERATION	DATE	ILLNESS/HOSPITALIZATION

SOCIAL HISTORY

ALCOHOL:	LIGHT	MODERATE	HEAVY			
CAFFEINE:	LIGHT	MODERATE	HEAVY	CUPS PER DAY:		
EXERCISE:	LIGHT	MODERATE	HEAVY			
SMOKING:	NEVER	PREVIOUS	CURRENT	QUIT	PACKS PER DAY:	YEARS:

REVIEW OF SYSTEMS: Check any symptoms you have experienced or are currently experiencing

GENERAL	SKIN	HEAD	EYES	EARS
❑ WEAKNESS ❑ FATIGUE ❑ FEVER ❑ CHILLS ❑ CANCER ❑ ARTHRITIS ❑ GOUT ❑ ANEMIA ❑ NONE	❑ SKIN COLOR CHANGES ❑ SKIN RASHES ❑ ITCHY SKIN ❑ SKIN SORES ❑ PSORIASIS ❑ ECZEMA ❑ BRUISING ❑ NONE	❑ HEADACHES ❑ HEAD INJURY ❑ HEAD LESIONS ❑ FACIAL LESION ❑ NONE	❑ BLURRED VISION ❑ EYE REDNESS ❑ ITCHY EYES ❑ EYE SWELLING ❑ EYE PAIN ❑ DRY EYES ❑ TEARING ❑ DOUBLE VISION ❑ GLAUCOMA ❑ NONE	❑ HEARING LOSS ❑ RINGING ❑ EAR DISCHARGE ❑ EARACHE ❑ ITCHY EARS ❑ LOSS OF BALANCE ❑ DIZZINESS ❑ ROOM SPINS ❑ EAR BLOCKAGE ❑ EAR INFECTIONS ❑ LESIONS/SORES ❑ DEFORMITY ❑ NONE
NOSE	**MOUTH**	**THROAT**	**NECK**	**LUNGS**
❑ LOSS OF SMELL ❑ NOSE BLEEDS ❑ NASAL PAIN ❑ NASAL DISCHARGE ❑ NASAL OBSTRUCTION ❑ NASAL CONGESTION ❑ SNORING/SLEEP APNEA ❑ POST NASAL DRIP ❑ DEVIATED SEPTUM ❑ NASAL SORES/LESIONS ❑ SINUSITIS ❑ NONE	❑ BLEEDING GUMS ❑ ORAL SORES ❑ DENTAL PROBLEMS ❑ MOUTH/JAW PAIN ❑ BAD BREATH ❑ LOSS OF TASTE ❑ DRY MOUTH ❑ BAD TASTE ❑ NONE	❑ SORE THROAT ❑ TONSILLITIS ❑ HOARSENESS ❑ DIFFICULTY SWALLOWING ❑ RECURRENT INFECTIONS ❑ ORAL WHITE SPOTS ❑ NONE	❑ NECK ENLARGEMENT ❑ NECK STIFFNESS ❑ NECK SORENESS/PAIN ❑ NECK LUMPS ❑ NECK MASS ❑ NONE	❑ COUGH ❑ PHLEGM ❑ COUGHING BLOOD ❑ SHORTNESS OF BREATH ❑ WHEEZING ❑ PAIN IN LUNGS ❑ CHEST CONGESTION ❑ ASTHMA ❑ BRONCHITIS ❑ PNEUMONIA ❑ NONE
HEART	**GASTROINTESTINAL**	**NEUROLOGICAL**	**PSYCHIATRIC**	**ENDOCRINE**
❑ MURMUR ❑ PALPITATIONS ❑ RAPID HEARTBEAT ❑ TIGHTNESS/PRESSURE ❑ CHEST PAIN ❑ VARICOSE VEINS ❑ BLOOD CLOTS ❑ PHLEBITIS ❑ HIGH BLOOD PRESSURE ❑ NONE	❑ ABDOMINAL PAIN ❑ NAUSEA ❑ VOMITING ❑ HEARTBURN ❑ GERD ❑ INDIGESTION ❑ LOSS OF APPETITE ❑ DIVERTICULOSIS ❑ JAUNDICE ❑ HEMORRHOIDS ❑ KIDNEY STONES ❑ NONE	❑ SEIZURES ❑ VERTIGO ❑ MEMORY LOSS ❑ PARALYSIS ❑ TINGLING/NUMBING ❑ DISORIENTATION ❑ STROKE ❑ NONE	❑ ANXIETY ❑ ALCOHOL ABUSE ❑ SUBSTANCE ABUSE ❑ DRUG USE ❑ NERVOUSNESS ❑ DEPRESSION ❑ MENTAL ILLNESS ❑ PHOBIAS ❑ NONE	❑ WEIGHT LOSS ❑ WEIGHT GAIN ❑ HYPOGLYCEMIA ❑ DIABETES ❑ THYROID DISEASE ❑ RECENT HAIR LOSS ❑ NONE