

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 any 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

<p><i>Neurologic</i></p> <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Bell's palsy <input type="checkbox"/> Stroke/mini-stroke <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Seizures <input type="checkbox"/> Migraines <input type="checkbox"/> Chronic headaches <p><i>Eyes/Ear/Nose/Throat</i></p> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Laryngitis <input type="checkbox"/> Recurrent tonsillitis <input type="checkbox"/> Reflux <input type="checkbox"/> Recurrent sinusitis <input type="checkbox"/> Cholesteatoma <input type="checkbox"/> Vasomotor rhinitis <input type="checkbox"/> Otitis media/externa <input type="checkbox"/> Allergic rhinitis <input type="checkbox"/> Parotid swelling, recurrent <input type="checkbox"/> Chronic cough <input type="checkbox"/> Sleep apnea/snoring <input type="checkbox"/> Otosclerosis <input type="checkbox"/> Recurrent ear infections <p><input type="checkbox"/> Cancer (including skin): _____</p> <p><input type="checkbox"/> Skin condition (i.e., vascular marking, rosacea, psoriasis, eczema): _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Any genetic syndrome: _____</p> <p>Any spinal disorder: _____</p>	<p><i>Pulmonary/Cardiovascular</i></p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Abnormal EKG/heart rhythm (_____) please specify _____ <input type="checkbox"/> Heart aneurysm <input type="checkbox"/> Carotid disease <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Asthma/Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Angina <input type="checkbox"/> Heart disease <input type="checkbox"/> Enlarged heart <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Valvular disease/murmur please specify _____ <input type="checkbox"/> Congestive heart failure (CHF) <input type="checkbox"/> High/low cholesterol (circle one) <input type="checkbox"/> Heart attack <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chronic cough <p><i>Musculoskeletal</i></p> <input type="checkbox"/> Juvenile Rheumatoid arthritis <input type="checkbox"/> Joint disease <input type="checkbox"/> Gout <input type="checkbox"/> Neck/back disease <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Carpal tunnel syndrome <input type="checkbox"/> Anemia <input type="checkbox"/> Frequent falls <input type="checkbox"/> Juvenile Rheumatoid arthritis	<p><i>Infectious Disease</i></p> <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> AIDS <input type="checkbox"/> Rubella <input type="checkbox"/> Chicken pox <input type="checkbox"/> Recurrent <i>Strep</i> infections <p><i>Endocrine/Psychiatric/Misc</i></p> <input type="checkbox"/> Diabetes- non-insulin dependent <input type="checkbox"/> Diabetes – insulin-dependent <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Anxiety <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Panic attacks <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Depression <p><i>Gastrointestinal/Genitourinary</i></p> <input type="checkbox"/> BPH <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Gall bladder disease <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Kidney disease/stones <input type="checkbox"/> Hepatitis (please specify _____) <input type="checkbox"/> Peptic ulcer disease
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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

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

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Back Surgery |
| <input type="checkbox"/> Carotid endarterectomy | <input type="checkbox"/> Cataract Excision | <input type="checkbox"/> Cholecystectomy | |
| <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Coronary artery bypass | |
| <input type="checkbox"/> Ear surgery- ear drum repair (tympanoplasty) | <input type="checkbox"/> Ear Surgery – mastoid surgery (mastoidectomy) | | |
| <input type="checkbox"/> Brain surgery | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Rhinoplasty | <input type="checkbox"/> Septoplasty |
| <input type="checkbox"/> Sinus surgery | <input type="checkbox"/> Sinus surgery (please specify) _____ | | |
| <input type="checkbox"/> Thyroidectomy, total | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Tonsillectomy and adenoidectomy (T&A) | |
| <input type="checkbox"/> Turbinate reduction | <input type="checkbox"/> P.E.T (ear tubes) | | |
| <input type="checkbox"/> 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:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Wears glasses | <input type="checkbox"/> Blurring of vision | <input type="checkbox"/> Redness | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Wears contacts | <input type="checkbox"/> Swelling | <input type="checkbox"/> Itchy eyes | |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Dryness of eyes | <input type="checkbox"/> Double vision | |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Discharge | <input type="checkbox"/> None= |

ENT:

- | | | | | |
|--|---------------------------------------|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> None | <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Decreased/lost smell | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nose pain | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Gum disease | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Septal perforation | <input type="checkbox"/> Sores on lips/gums |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Voice changes |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Postnasal drip | <input type="checkbox"/> Throat pain |
| <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nasal discharge | <input type="checkbox"/> Rhinorrhea | <input type="checkbox"/> Bad breath/taste |
| <input type="checkbox"/> Ear drainage | <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Nasal obstruction | <input type="checkbox"/> 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 (hematemesis) 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