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PATIENT'S NAME:_____ **DATE OF VISIT**: ____/____/____

DATE OF BIRTH: _____/_____/_____ **OCCUPATION** _____

REASON FOR VISIT: _____

CURRENT MEDICINES/DOSES: 1. _____ **ALLERGIES TO MEDICINES:**

2. _____ 5. _____ 1. _____

3. _____ 6. _____ 2. _____

4. _____ 7. _____

PLEASE LIST ALL PRIOR MAJOR ILLNESSES/SURGERIES (with years)

Illnesses/Injuries 1. _____ 2. _____ 3. _____

Hospitalizations 1. _____ 2. _____ 3. _____

Operations 1. _____ 2. _____ 3. _____

FAMILY HISTORY (please check) ____Heart Disease ___Diabetes ___ Cancer ___ Other _____

Which family member?_____

Do you drink soda/coffee/tea? __ No, *never* __ No, *but I used to* __ Yes ~ Cups/Drinks per day? _____

Do you drink alcohol? __ No, *never* __ No, *but I used to* __ Yes ~ How many drinks? _____/day or wk?

Do you smoke? __ No, *never* __ No, *but I used to* __ Yes ~ Packs per day? _____x_____ years

Do you use illicit drugs? __ No, *never* __ No, *but I used to* __ Yes ~ Which? _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (circle Y or N)

CONSTITUTIONAL			**CARDIOVASCULAR**			**GENITOURINARY**		
weight gain/loss(>15lbs)	Y	N	heart attack	Y	N	frequent urination	Y	N
constant night sweats	Y	N	high blood pressure	Y	N	prostate problems n/a	Y	N
			heart murmur	Y	N			
EYES			**GASTROINTESTINAL**			**SKIN**		
double vision	Y	N	diarrhea	Y	N	past skin cancer	Y	N
glaucoma	Y	N	heartburn	Y	N	past radiation therapy	Y	N
EAR/NOSE/THROAT			**ENDOCRINE**			**MUSCULOSKELETAL**		
hearing loss	Y	N	diabetes	Y	N	arthritis	Y	N
ear pain	Y	N	thyroid disease	Y	N	back pain	Y	N
ringing in ears	Y	N	autoimmune disease	Y	N	**RESPIRATORY**		
balance problems	Y	N	**NEUROLOGIC**			asthma/emphysema	Y	N
hearing aid	Y	N	headaches	Y	N	chronic cough	Y	N
difficulty breathing	Y	N	seizures	Y	N	Tuberculosis	Y	N
nosebleeds	Y	N	stroke	Y	N	**PSYCHIATRIC**		
nasal drainage	Y	N	**HEMATOLOGY**			anxiety	Y	N
sinus problems	Y	N	bruise easily	Y	N	depression	Y	N
snoring	Y	N	anemia	Y	N	sleep problems	Y	N
voice changes	Y	N	cancer	Y	N			

OTHER _____

If YES to any of the above, please explain:_____

_____

Reviewed by: _____ M.D.