Patient History Form

Patient Name:			Pr	imary Care	e Physician	:		
What is the reason for you	ur visit toda	y?						
Medical History List your present medicat Medication	•	Frequency	ſ	Medication		Dos	age/Freque	
Are you on blood thinner, ib								
List all past/present medica	al illnesses							
1			4	1				
2				5				
3								
	Approxim							
Do You?								
Yes No Yes No Yes No Yes No Yes No	Drink? If Chew? Are you a	yes, circle o previous sn	one: Wine	Beer V	Vhiskey lid you quit?			
Family History Diabetes	No History	Un Known	Mother	Father	Grand Mother	Grand Father	Siblings	Aunts or Uncles
Cancer								
Heart Disease								
High Blood Pressure								
Asthma								
History of Bleeding								
Hearing problems								
Allergy/Sinus Problems				ļ				
Other:				ļ				
Other:								
Other:								

Review of Systems

Decreased Hearing	Last Name:		First Name:		Middle:				
Decreased Hearing	Social Security #:		Date of Birth://		Today's Date:/	_/_	_/		
Decreased Hearing	Do you have any proble	ms relat	ed to	the following? Please circle	Yes or	No			
Pain	Ear:			Mouth:			Skin:		
Fullness	Decreased Hearing	Υ	Ν	Sores on Tongue	Υ	Ν	Skin Rash	Υ	Ν
Infection	Pain	Υ	Ν	Gum Swelling	Υ	Ν	Hives	Υ	Ν
Nome	Fullness	Υ	Ν	Lumps/Growth	Υ	Ν	Persistent Itch	Υ	N
Ringing	Infection	Υ	Ν	Bleeding	Υ	Ν	Other	Υ	N
Hearing Aids	Ringing	Υ	Ν	Loss of Taste	Υ	Ν			
Drainage/Bleeding	Dizziness	Υ	Ν	Pain	Υ	Ν	Musculoskeletal:		
Page	Hearing Aids	Υ	Ν	Bad Breath	Υ	Ν	Joint Pain	Υ	Ν
Sepant S	Drainage/Bleeding	Υ	Ν	Other	_ Y	Ν	Neck Pain/Back Pain	Υ	Ν
Watery	OtherY		N				Muscle Weakness	Υ	Ν
Blockage/Breathing				Eyes:			Other	Υ	Ν
Congestion	Nose:			Watery	Υ	Ν			
Drainage	Blockage/Breathing	Υ	Ν	Drainage	Υ	Ν	Respiratory:		
	Congestion	Υ	Ν	Itching	Υ	Ν	Wheezing	Υ	N
Trauma	Drainage	Υ	Ν	Change in Vision	Υ	Ν	Frequent Cough	Υ	Ν
Selecting	Infection	Υ	Ν	Redness	Υ	Ν	Shortness of Breath	Υ	Ν
Bleeding	Trauma	Υ	N				Other	Υ	Ν
No	Sneezing	Υ	Ν	Neurological:					
Numbness/Tingling	Bleeding	Υ	Ν	Tremors/Seizures	Υ	Ν	Hematological/Lymphatic:		
Headache	Loss of Smell	Υ	Ν	Dizzy Spells	Υ	Ν	Swollen Glands	Υ	Ν
Cher	Other	Y	Ν	Numbness/Tingling	Υ	Ν	Blood Clotting Problems	Υ	Ν
Lumps/Growth Y N Endocrine: Depression Y N Swelling Y N Diabetes Y N Anxiety Y N Dryness/Itching Y N Too Hot/Cold Y N Medication Y N ToosHillitis Y N Tired/Sluggish Y N Other				Headache	Υ	Ν	Other	Υ	Ν
Pain	Throat:			Other	_ Y	N			
Swelling Y N Diabetes Y N Anxiety Y N Dryness/Itching Y N Too Hot/Cold Y N Medication Y N N Other Y N N Other Y N N Hair Loss Y N Medication Y N N Hair Loss Y N N Hair Loss Y N N Hair Loss Y N Medication Y N N Other Y N Medication Y N Hair Loss Y N N Hay Fever Y N N Hay Fever Y N N Hay Fever Y N N Fatigue Y N Fatigue Y N Food Allergies Y N N Other Y N Medication Y N Other Y N Medication Y N Other Y N Medication Y N Other Y N N Night Sweats Y N N Night Sweats Y N N Headaches Y N N Indigestion/Heartburn Y N Hepatitis Y N N Headaches Y N N Night Time Cough Y N Other Y N Other Y N Other Y N Other Y N N Other Y N N Other Y N Other Y N N Other Y N High Blood Pressure Y N N Other Y N High Blood Pressure Y N N	Lumps/Growth	Υ	Ν				Psychological/Emotional:		
Dryness/Itching Y N Too Hot/Cold Y N Medication Y N Tonsillitis Y N Tired/Sluggish Y N Other	Pain	Υ	Ν	Endocrine:			Depression	Υ	Ν
Tonsillitis	Swelling	Υ	Ν	Diabetes	Υ	N	Anxiety	Υ	Ν
Hoarseness Y N Hair Loss Y N Voice Change/Loss Y N Weight Loss Y N Hay Fever Y N Cough Y N Muscle Pain Y N Drug Allergies Y N Other Y N Fatigue Y N Food Allergies Y N Constipation Y N Tother Y N Constipation Y N Gastrointestinal: Eye/Facial Swelling Y N Gastrointestinal: Change in Vision Y N Abdominal Pain Y N Night Sweats Y N Drainage Y N Nausea/Vomiting Y N Hepatitis Y N Infection Y N Night Time Cough Y N Congestion Y N Trouble Swallowing Y N Polyps Y N Other Y N Cardiovascular: Chest Pain Y N High Blood Pressure Y N	Dryness/Itching	Υ	Ν	Too Hot/Cold	Υ	N	Medication	Υ	N
Hoarseness Y N Hair Loss Y N Voice Change/Loss Y N Weight Loss Y N Allergic/Immunological: Frequent Clearing Y N Weight Gain Y N Hay Fever Y N Cough Y N Muscle Pain Y N Drug Allergies Y N Other	Tonsillitis	Υ	Ν	Tired/Sluggish	Υ	Ν	Other	Υ	Ν
Frequent Clearing Y N Weight Gain Y N Hay Fever Y N Cough Y N Muscle Pain Y N Drug Allergies Y N Other Y N Fatigue Y N Food Allergies Y N Constipation Y N Other Y N Other Y N Eye/Facial Swelling Y N Gastrointestinal: Frequently Tired Y N N Abdominal Pain Y N N Night Sweats Y N N Night Clongestion Y N Night Time Cough Y N Hepatitis Y N N Night Time Cough Y N Other Y N Cardiovascular: Chest Pain Y N High Blood Pressure Y N Other Y N High Blood Pressure Y N N Night Blood Pressure Y N N High Blood Pressure Y N N P N N High Blood Pressure Y N N P N P N P P N P P N P P N P P N P P N P P N P P N P P N P P N P P N P P P N P P N P P N P P N P P N P P N P P N P P N P P N P P P N P P	Hoarseness	Υ	N	Hair Loss	Υ	Ν			
Cough Y N Muscle Pain Y N Drug Allergies Y N Other Y N Fatigue Y N Food Allergies Y N Food Allergies Y N Food Allergies Y N Food Allergies Y N Other Y N Food Allergies Y N N Other Y N Other Y N Food Allergies Y N N Other Y N Food Allergies Y N N Food Allergies Y N N Other Y N Other Y N Other Frequently Tired Y N N Pain/Pressure Y N Abdominal Pain Y N Night Sweats Y N N Night Pain Y N Night Sweats Y N N Night Sweats Y N N AIDS Y N Headaches Y N Indigestion/Heartburn Y N Hepatitis Y N N Infection Y N Night Time Cough Y N Other Y N High Blood Pressure Y N N High Blood Pressure Y N Irregular Heart Rate Y N N Irregular Heart Rate Y N N	Voice Change/Loss	Υ	N	Weight Loss	Υ	Ν	Allergic/Immunological:		
Other	Frequent Clearing	Υ	Ν	Weight Gain	Υ	N	Hay Fever	Υ	Ν
Constipation Y N Other Y N Sinus: Other Y N Eye/Facial Swelling Y N Change in Vision Y N Gastrointestinal: Pain/Pressure Y N Abdominal Pain Y N Night Sweats Y N Drainage Y N N Nausea/Vomiting Y N AIDS Y N Headaches Y N Indigestion/Heartburn Y N Hepatitis Y N Infection Y N Night Time Cough Y N Congestion Y N Trouble Swallowing Y N Polyps Y N Other Y N Chest Pain Y N High Blood Pressure Y N Irregular Heart Rate Y N	Cough	Υ	Ν	Muscle Pain	Υ	N	Drug Allergies	Υ	Ν
Sinus: OtherY N Eye/Facial Swelling Y N Change in Vision Y N Gastrointestinal: Frequently Tired Y N Pain/Pressure Y N Abdominal Pain Y N Night Sweats Y N Drainage Y N Nausea/Vomiting Y N AIDS Y N Headaches Y N Indigestion/Heartburn Y N Hepatitis Y N Infection Y N Night Time Cough Y N Other Y N Congestion Y N Trouble Swallowing Y N Polyps Y N Other Y N Cardiovascular: Other Y N Irregular Heart Rate Y N	Other	Y	Ν	Fatigue	Υ	N	Food Allergies	Υ	Ν
Eye/Facial Swelling Y N General: Change in Vision Y N Gastrointestinal: Frequently Tired Y N Pain/Pressure Y N Abdominal Pain Y N Night Sweats Y N Drainage Y N Nausea/Vomiting Y N AIDS Y N Headaches Y N Indigestion/Heartburn Y N Hepatitis Y N Infection Y N Night Time Cough Y N Other				Constipation	Υ	Ν	Other	Υ	N
Change in Vision Y N Gastrointestinal: Frequently Tired Y N Pain/Pressure Y N Abdominal Pain Y N Night Sweats Y N Nightage Y N Nausea/Vomiting Y N AIDS Y N Headaches Y N Indigestion/Heartburn Y N Hepatitis Y N Infection Y N Night Time Cough Y N Other Y N Other Y N Other Y N Polyps Y N Other Y N Cardiovascular: Other Y N High Blood Pressure Y N Irregular Heart Rate Y N	Sinus:			Other	Y	Ν			
Pain/Pressure Y N Abdominal Pain Y N Night Sweats Y N Drainage Y N Nausea/Vomiting Y N AIDS Y N Headaches Y N Indigestion/Heartburn Y N Hepatitis Y N Infection Y N Night Time Cough Y N Other Y N Congestion Y N Trouble Swallowing Y N Polyps Y N Other Y N Cardiovascular: Other Y N High Blood Pressure Y N Irregular Heart Rate Y N	Eye/Facial Swelling	Υ	Ν				General:		
Drainage Y N Nausea/Vomiting Y N AIDS Y N Headaches Y N Indigestion/Heartburn Y N Hepatitis Y N Infection Y N Night Time Cough Y N Other Y N Congestion Y N Trouble Swallowing Y N Polyps Y N Other Y N Cardiovascular: Other Y N High Blood Pressure Y N Irregular Heart Rate Y N	Change in Vision	Υ	N	Gastrointestinal:			Frequently Tired	Υ	Ν
Headaches Y N Indigestion/Heartburn Y N Hepatitis Y N Infection Y N Night Time Cough Y N Other Y N Congestion Y N Trouble Swallowing Y N Polyps Y N Other Y N Cardiovascular: Other Y N High Blood Pressure Y N Irregular Heart Rate Y N	Pain/Pressure	Υ	Ν	Abdominal Pain	Υ	Ν	Night Sweats	Υ	N
Infection Y N Night Time Cough Y N Other Y N Congestion Y N Trouble Swallowing Y N Polyps Y N Other Y N Cardiovascular: Chest Pain Y N High Blood Pressure Y N Irregular Heart Rate Y N	Drainage	Υ	Ν	Nausea/Vomiting	Υ	N	AIDS	Υ	Ν
Congestion Y N Trouble Swallowing Y N Polyps Y N Other Y N Cardiovascular: Other Y N High Blood Pressure Y N Irregular Heart Rate Y N	Headaches	Υ	Ν	Indigestion/Heartburn	Υ	N	Hepatitis	Υ	N
Congestion Y N Trouble Swallowing Y N Polyps Y N Other Y N Cardiovascular: Other Y N High Blood Pressure Y N Irregular Heart Rate Y N	Infection	Υ	Ν	_	Υ	Ν		Υ	Ν
Polyps Y N Other Y N Cardiovascular: Other Y N Cardiovascular: Chest Pain Y N High Blood Pressure Y N Irregular Heart Rate Y N	Congestion	Υ	Ν		Υ	Ν			
Other	Polyps	Υ	Ν		_ Y		Cardiovascular:		
High Blood Pressure Y N Irregular Heart Rate Y N		_ Y	Ν					Υ	N
Irregular Heart Rate Y N		-						Υ	
								Υ	
Other Y N							Other	Υ	N

CONSENT FOR TREATMENT OF A MINOR

A minor is anyone 17 years of age or younger.

Patient Name	Patient DOB				
Thank your for entrusting the care of your provide the best quality of care for your chappointments. We realize that your child n guardian may be unable to be present. By of your child during your absence.	nild we require that a parent on nay need to be seen for an acu	r legal guardian accompany the child to te sick visit and a parent or legal			
In the absence of a parent or legal guardia and treatment for my child. I also realize the information if medically necessary. These it visit. If someone other than these persons or legal guardian for verbal permission to the	hat the person below may have individuals will be asked to pre listed below brings in your chi	e access to pertinent protected health sent identification at the time of the			
NAME	RELATIONSHIP	PHONE			
1.					
_					
3.					
4					
Please be sure the person accompanying y illness in order to provide the highest qual		information regarding your child's			
Signature	Relationship	Date			
Parent(s) or Legal Guardian(s) contact info	rmation:				
Name:	Name:				
Relationship:					
Home Number:	Home Number:				
Cell Number:	Cell Number:				
Work Number:	Work Number:	<u> </u>			