Patient Name:_____Date of Birth:_____

Chief Complaint

Reason for today's visit?_____

Who referred you to our office:_____

Current problem is the result of a(n): Check all that apply

☐Car Accident ☐Work Accident ☐Accident ☐Other_____
IF RELATED TO AN ACCIDENT, PLEASE PROVIDE THE SECRETARY WITH THE CORRECT THIRD PARTY LIABILITY CARRIER INFORMATION

Past History

Please list any prior major illnesses and/or injuries:_____
_____
_____
_____

Surgeries/Hospitalization Year Complications _____
_____
_____
_____
_____
_____

Have you ever had problems with anesthesia? ☐Yes ☐No
ALLERGIES TO MEDICATIONS:

ALLERGY TO LATEX ☐Yes ☐No

Current Medication(s) Dose Frequency_____
_____
_____
_____
_____
_____
_____
_____

Patient Name:_____Date of Birth:_____

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

Occupation:_____

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed

Do you have children? ☐Yes ☐No How many?_____

Do you live alone ☐Yes ☐No Who lives with you?_____

Do you smoke: ☐Yes, I've smoked_____packs of cigarettes per day for _____years.
☐Yes, I smoke cigars or a pipe
☐No, I have never smoked
☐No, I quit_____years ago. At that time I was smoking_____packs per day for_____years.

Do you drink alcohol? ☐No, never(or rarely) ☐No, but I used to
☐Yes ☐Daily ☐1 or more times a week ☐1 or more times a month

Are you at risk for AIDS(e.g. sexual orientation, drug abuse, previous blood transfusion)?
☐No ☐Yes, please explain:_____

Review of Systems

Are you currently, or have you had problems with:

Constitutional	Circle One
Fever	Yes No
Weight Loss	Yes No
Excessive Fatigue	Yes No

Eyes	Circle One
Glaucoma	Yes No
Cataracts	Yes No

Patient Name:_____Date of Birth:_____

Ears, Nose, Throat and Mouth

Hearing Loss	Yes	No
Ear Pain	Yes	No
Ear Infections	Yes	No
Ringing In Ears Circle: Left Right Both	Yes	No
Balance Disturbance e.g. Vertigo, Spinning)	Yes	No
Inability To Smell	Yes	No
Sinus Problems	Yes	No

Cardiovascular

Chest Pain or Angina-Date of last EKG_____ Stress test_____ Echocardiogram_____	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
High Cholesterol	Yes	No

Respiratory

Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No

Gastrointestinal

Nausea	Yes	No
Vomiting	Yes	No
Liver Disease	Yes	No
Jaundice	Yes	No
Change in Your Bowel Habits	Yes	No
Ulcers or Gastritis	Yes	No

Genitourinary

Urinary Tract Infections	Yes	No
Painful Urination	Yes	No
Blood in Urine	Yes	No
Incontinence	Yes	No

Musculoskeletal

Arm or Leg Pain	Yes	No
Arthritis	Yes	No

Patient Name:_____Date of Birth:_____

Neurological

Fainting Spells	Yes	No
Seizures	Yes	No
Problems with your Memory	Yes	No
Disorientation	Yes	No
Difficulty with Your Speech	Yes	No
Inabililty to Concentrate	Yes	No
Double or Blurred Vision	Yes	No
Face Weakness	Yes	No
Coordination in Arm and/or Legs	Yes	No

Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder/Treatment_____	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No

Hematologic/Lymphatic

Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands or Lymph Nodes	Yes	No

Allergic/Immunologic

Food Allergies	Yes	No
Inhalant (nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No

The above information is accurate to the best of my knowledge.

_____ _____
Patient Signature Date

I have reviewed the above information with the patient.

_____ _____
Physician Signature Date

_____ _____
Physician Signature Date

_____ _____
Physician Signature Date

_____ _____
Physician Signature Date