

Personal Information

Name _____

DOB _____

Address _____

Phone # _____

Email _____

Emergency Contact Name _____

Phone # _____

Referring Provider _____

Primary Care Provider _____

Reason for Visit _____

Allergies:

No Known Drug Allergies

Outdoor Allergies _____

Indoor Allergies _____

Food Allergies _____

Medication Allergies _____

Smoking Status:

Never Smoker

Former Smoker

Current Smoker

Current Medications:

Medical History/ Conditions- Current or treated in the past. (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Post Nasal Drip |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Fever | <input type="checkbox"/> Mucous in Nose/Throat |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Production of Sputum |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Recurrent Sinusitis |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Recurrent Urinary Tract Infections |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Runny Nose |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Seizures Disorder or Epilepsy |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Heartburn/ Gastric Reflux | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Cancer (Specify Below) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Spitting Blood |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> HIV/AIDS Positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tinnitus/ Ear Ringing |
| <input type="checkbox"/> COPD/Breathing Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Vertigo/ Dizziness |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Weakness of the Extremities |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Wheals |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> None |

Surgical History (Indicate all that apply)

Date of Surgery _____

Date of Surgery _____

Date of Surgery _____

Date of Surgery _____

Date of Surgery _____