PATIENT HEALTH HISTORY FORM

GENERAL INFORMATION

PATIENT'S NAME _____ AGE _____ SEX _____ DATE _____

PARENT _____ PHONE _____

ADDRESS _____ OCCUPATION _____

REFERRED BY _____

MEDICAL INFORMATION

A. GENERAL ALLERGY SYMPTOMS - Check box beside symptoms associated with your allergies:

- ☐ Worse outdoors
- ☐ Worse on windy days
- ☐ Worse on clear days
- ☐ Worse outdoors 7 to 11 a.m.
- ☐ Worse in change of temperature
- ☐ Worse in warm or cool air
- ☐ Better indoors
- ☐ Better outdoors
- ☐ Worse indoors
- ☐ Worse 30 minutes after retiring
- ☐ Worse in cold weather
- ☐ Worse when sweeping
- ☐ Worse when dusting
- ☐ Worse outdoors from 4 to 9 p.m.
- ☐ Worse on cool evenings
- ☐ Worse in low, damp place
- ☐ Worse mowing or playing in grass
- ☐ Worse after lights are on 1 hour
- ☐ Worse in certain rooms
  Which one _____
- ☐ Worse in basement
- ☐ Worse near a barn
- ☐ Worse around animals
  Which ones _____

B. MEDICAL HISTORY

1. What prescription and non-presciption medications do you take?

- ☐ Aspirin
- ☐ Cortisone (Steroids)
- ☐ Diabetes Med
- ☐ High Blood Pressure Med
- ☐ Sedatives
- ☐ Heart Disease Med
- ☐ Antidepressants
- ☐ Vitamins
- ☐ Asthma Med
- ☐ Thyroid Medication
- ☐ Nose Drops/Sprays
- ☐ Hormones
- ☐ Antihistamines
- ☐ Decongestants
- ☐ Anticholesterol Drugs

Please list names and dosages on Medication Chart.

2. Are you allergic to any medications? _____ If yes, please list _____

3. Check the following medical conditions you are experiencing or have experienced in the past:

- ☐ High Blood Pressure
- ☐ Thyroid Dysfunction
- ☐ Seizures
- ☐ Stomach or Intestinal Dis
- ☐ Skin Disease
- ☐ Sinus Disease
- ☐ Nasal Surgery
- ☐ Bronchitis
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Nasal Polyps
- ☐ Frequent Headaches
- ☐ Migraine Headache
- ☐ Croup
- ☐ Emphysema
- ☐ Hives
- ☐ Colitis
- ☐ Diabetes
- ☐ Other: _____

SMOKING HABITS:
Cigarettes # _____/day
Pipe # _____/day
Cigars # _____/day
Years Smoked _____
Stopped Smoking in _____

ALCOHOL INTAKE
- ☐ Daily
- ☐ Weekly
- ☐ Special Occasions
- ☐ Never

ILLICIT DRUG USE
- ☐ Marijuana
- ☐ Cocaine
- ☐ Other

CHECK THE FOLLOWING THAT APPLY:
- ☐ Family Problems
- ☐ School Problems
- ☐ Frequently Absent From School/Work
- ☐ Over-anxious
- ☐ Divorced
- ☐ Separated

4. List all surgeries and hospitalizations:

Date	Type of Surgery	Reason

5. List physicians who participate in your care:

Name	Address / Phone	Reason

C. FAMILY HISTORY OF MEDICAL PROBLEMS:

SYSTEMS REVIEW

A. EAR, NOSE, THROAT & ALLERGY

1. Nose:
   - ☐ Stuffy
   - ☐ Runny
   - ☐ Itching
   - ☐ Post Nasal Drainage

2. **Ears:**
   - ☐ Stopped up feeling
   - ☐ Itching
   - ☐ Sore

3. **Nasal Blocking:**
   - ☐ Alternating from one side to the other
   - ☐ Constant
   - ☐ Night, what time _____
   - ☐ Day, what time_____
   - ☐ After meals, how long _____
   - ☐ Year round
   - ☐ Seasonal, which _____

4. **Mouth:**
   - ☐ Roof itch
   - ☐ Tongue coated
   - ☐ Ulcerated
   - ☐ Lips swell
   - ☐ Throat itch

5. **Eyes:**
   - ☐ Water
   - ☐ Itch
   - ☐ Swelling
   - ☐ Burn

6. **Cough:**
   - ☐ Year round
   - ☐ Seasonal
   - ☐ Daytime
     - ☐ a.m. ☐ p.m.
   - ☐ Worse after a cold

7. **Itching:**
   - ☐ Eyes
   - ☐ Ears
   - ☐ Between Shoulders
   - ☐ Throat
   - ☐ Feet
   - ☐ Hands

Worse In:
- ☐ Winter
- ☐ Spring
- ☐ Summer
- ☐ Fall

8. **Sneezing:**
   - ☐ Year round
   - ☐ Seasonal
   - ☐ In early a.m.
   - ☐ At meal time
   - ☐ 30 minutes after eating
   - ☐ Smoky places
   - ☐ Dust

9. **General Symptoms:**
   - ☐ Pain, where _____
   - ☐ Nose bleeds
   - ☐ Weight loss
   - ☐ Tire out easily
   - ☐ Sore throats often
   - ☐ Cannot sleep
   - ☐ Nightsweats
   - ☐ Temperature
   - ☐ Cold frequently

B. CONSTITUTIONAL

1. **Fevers:**
   - ☐ Yes
   - ☐ No

2. **Weight Loss:**
   - ☐ Yes, how much _____
   - ☐ Dieting

3. **Night Sweats:**
   - ☐ Yes
   - ☐ No

C. EYES

1. **Vision changes:**
   - ☐ Yes
   - ☐ No

2. **Wears Glasses/Contacts:**
   - ☐ Yes
   - ☐ No

D. GASTROINTESTINAL

1. **Appetite:** Good _____ Picky _____ Poor _____
2. **Bowels:** Constipated _____ Regular _____
3. **Stools:** Diarrhea _____ Solid or mucus _____ Normal _____
4. **MOUTH:**
   - ☐ Offensive breath
   - ☐ Swallowing difficulties
   - ☐ Sores

STOMACH:
- ☐ Choking feeling
- ☐ Bloating
- ☐ Indigestion
- ☐ Nausea
- ☐ Retasting
- ☐ Vomiting
- ☐ Gas

RECTUM:
- ☐ Irritated ☐ Pain
- ☐ Raw ☐ Itchy

E. RESPIRATORY

1. **Difficulty Breathing**
   - ☐ Day
   - ☐ Night
   - ☐ With exercise
   - ☐ Need to use inhaler
   - ☐ No difficulty breathing

F. CARDIOVASCULAR

1. **Pain in Chest**
   - ☐ With exercise
   - ☐ Stationary
   - ☐ No chest pain
   - ☐ No swelling

2. **Swelling**
   - ☐ Legs
   - ☐ Feet
   - ☐ Hands

G. NEURLOGICIAL

1. Migraine History
   - ☐ Daily
   - ☐ Weekly
   - ☐ Monthly
   - ☐ No problems with headaches

2. Ringing in ears
   - ☐ Yes
   - ☐ No

3. Dizziness
   - ☐ Yes
   - ☐ No

H. SKELETAL

1. **Joint Pains**
   - ☐ Yes, which joints? _____
   - ☐ No

2. **Arthritis**
   - ☐ Yes, which joints? _____
   - ☐ No

3. **Muscle Pain**
   - ☐ Yes, where? _____
   - ☐ No

I. SKIN

1. **Rash**
   - ☐ Yes
   - ☐ No

2. **Hives**
   - ☐ Yes
   - ☐ In past
   - ☐ No

3. **Eczema**
   - ☐ Nom
   - ☐ Yes
   - ☐ In Past

J. GENITOURINARY

1. **Urination**
   - ☐ Painful
   - ☐ Delayed
   - ☐ Frequent
   - ☐ Prolonged
   - ☐ Bed Wetting
   - ☐ Infections
   - ☐ Normal

K. ENDOCRINE

1. **History of thyroid problems**
   - ☐ Hypothyroid
   - ☐ Hyperthyroid
   - ☐ No history of thyroid problems

2. **History of diabetes**
   - ☐ No
   - ☐ Yes

Patient Signature: _____ Date: _____

Physician Review: _____ Date: _____