

FAMILY HISTORY: Circle YES if anyone in your family has had the following:

ADD/ADHD	Yes	Hearing deficiency	Yes
Alcoholism	Yes	Hyperlipidemia	Yes
Allergies	Yes	Hypertension	Yes
Alzheimer's Disease	Yes	Irritable Bowel Syndrome	Yes
Asthma	Yes	Migraines	Yes
CAD (Coronary Artery Disease)	Yes	Nerve Hearing Loss	Yes
Cancer Type: _____	Yes	Obesity	Yes
CVA (Stroke)	Yes	Osteoarthritis	Yes
Depression	Yes	Osteoporosis	Yes
Developmental delay	Yes	PVD (Peripheral Vascular Disease)	Yes
Diabetes	Yes	Renal disease	Yes
Eczema	Yes	Seizure disorder	Yes
		Other: _____	

Tobacco Use? Yes No Former

Do you consume alcohol? Yes No Former

	Packs/Day	For? Years	Yr. Quit?		Type of Alcohol	Frequency?	Amount?	Last Drink?
Cigarettes								
Other:(list type)								

Exposed to second hand smoke? Yes No

Caffeine Consumption? Yes No Type: _____ Amount per day? _____

REVIEW OF SYSTEMS: Circle any of the following problems you have recently had:

General health problems:

fatigue fever night sweats unintentional weight loss sleeping problems weight gain

Eye problems:

double vision itchy eyes swelling redness

Ear problems:

ear drainage hearing loss ear infections dizziness itchy noise exposure ringing /noise in ears ear pain

Nose & Sinus problems:

chronic congestion mouth breathing nosebleeds frequent sneezing runny nose post-nasal drip

Mouth & Throat problems:

difficulty swallowing snoring sore throat hoarseness sores in mouth ulcers

Heart or circulation problems:

heart murmur leg cramping swelling of ankles chest pain blacking out irregular heartbeat

Lung or respiratory problems:

shortness of breath wheezing cough

Stomach problems:

abdominal pain diarrhea heartburn nausea vomiting

Brain or Nervous system problems:

headache seizures weakness numbness facial pain

Glands & Hormone problems:

intolerance to heat increased appetite neck enlargement intolerance to cold

Blood or Lymph nodes problems:

bleeds excessively after injury bruises easily

Allergy problems:

food intolerances insect bites

Skin:

rash itchy latex allergy swelling urticaria / hives

What is the reason you are here today? _____

Patient Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____