The Sinus Center
OF THE SOUTH

Today's Date: _____/_____/ _____

Who referred you to this office? _____

NAME:_____ D.O.B.____/____/____
First Middle Last

PROBLEM

For what problem are you seeing the physician today?_____

How would you describe the problem?_____

_____

When did it start? _____

Does anything make it better or worse? **NO** **YES** If yes, what makes it better? _____

What medicines or treatments have you tried?_____

MEDICATIONS

To which medications are you allergic?_____

What medications & dosage do you take? (include prescription, herbal, over-the-counter)

_____

_____

_____

MEDICAL HISTORY

Are you pregnant or believe that you may be pregnant? **NO** **YES**

Is there any personal history of prolonged or bleeding with surgeries or injuries? **NO** **YES**

Please circle and/or list your current medical problems: high blood pressure, high cholesterol, coronary artery disease, arrhythmia, diabetes, thyroid, asthma, COPD, acid reflux, cancer, other: _____

_____

Please circle and/or list all prior surgeries; tubes, adenoids, tonsils, septoplasty, sinus, ear, neck, thyroid, eye, breast, appendix, gall bladder, hysterectomy, C-section, abdominal, heart bypass, angioplasty [with or without stents], heart valve, knee, hip, back, shoulder, other, and when they were performed:_____

_____

FAMILY HISTORY

Circle all that apply

Allergic rhinitis:	Father	Mother	Siblings	Other _____
Cardiac:	Father	Mother	Siblings	Other _____
Cancer:	Father	Mother	Siblings	Other _____
Diabetes:	Father	Mother	Siblings	Other _____

SOCIAL HISTORY

Do you smoke? NO YES If yes: How many packs per day? _____ How long?_____

When did you stop smoking? _____ Before you quit, how much and how long?_____

Do you use smokeless tobacco? NO YES How many cans per day/week? _____

Do you drink alcohol? (beer/wine/liquor) NO YES

If yes, how much? _____ How often? _____

What is your occupation?_____ If retired, what was your former occupation?_____

PLEASE CIRCLE ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

WEIGHT GAIN / LOSS	WEAKNESS / DIZZINESS	SORE THROAT
HEADACHES	RUNNY / STUFFY NOSE	SNEEZING
CHEST TIGHTNESS	CHEST PAIN	SHORTNESS OF BREATH
WHEEZING	COUGH	VISUAL PROBLEMS
URINARY PROBLEMS	PALPITATIONS	NAUSEA / VOMITING
DIARRHEA / CONSTIPATION	HIVES	ITCHY / DRY SKIN
CHRONIC PAIN	RASH	SWOLLEN LYMPH NODES
FEVER / CHILLS / NIGHT	SWEATS	ITCHY / WATERY EYES