Ht: _____ ft. _____in. Wt:_____ lbs.
BP:_____/_____ Temp:_____F HR_____ O2_____%

1. Do you or any others in the home smoke cigarettes? Circle one: Yes No

2. Pets in home? Circe one: Yes No If yes, what type?_____

3. If student, what grade level? _____

4. If employed, occupation/employer? _____

5. Is there a family history of any of the below conditions? Please circle all that apply.

Asthma: Father Mother Sibling None

Nasal allergies: Father Mother Sibling None

Eczema: Father Mother Sibling None

6. Have you had any of the following, 3 or more days per week for the last 3 weeks? Circle any that apply.
Fever Chills Recent change in weight headache sinus pain

Difficulty breathing wheezing cough heartburn Vomiting diarrhea

joint pain fainting Easy bruising or bleeding swollen lymph nodes

7. Have you had any previous surgeries? Please circle. Yes No
If so, please list type and year _____

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8. Please list any chronic medical conditions or any medical conditions that you are currently being treated for._____

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9. Do you patient take any medications? Yes No
Please list, if yes_____

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10. Are you allergic to any medications? Circle one. Yes No
If so, please list medication and the reaction. _____

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11. Are you allergic to latex? Yes No