Name:_____ **Referred by:**_____

Date of Birth:_____ **Age:**_____ **Sex: M/ F** **PCP:**_____

Medical History: □ NONE

□ Allergies	□ Cancer	□ Diabetes	□ Migraines
□ Asthma	□ Heart Disease	□ Bleeding Disorder	□ Sleep Apnea
□ Hearing Loss	□ Hypertension	□ Autoimmune disease	□ HIV positive
□ Sinus	□ Stroke	□ Kidney Disease	□ Seizures
□ Thyroid	□ Cholesterol	□ Hepatitis	□ Other:
□ Nasal Polyps	□ Bronchitis	□ Emphysema	_____

Surgical History: □ NONE

□ Sinus/Nose	□ Ear Tubes	□ Tonsillectomy/Adenoidectomy	□ Thyroid
□ Appendectomy	□ Heart Surgery	□ Pacemaker/Defibrillator	□ Hysterectomy
□ Gallbladder	□ Breast Augmentation	□ Facial Plastic	

□ Other: _____

Medications: □ NONE

_____

_____

_____

Allergies:

□ NONE □ Penicillin □ Sulfa □ Codeine □ Latex □ Other:_____

Family History: □ NONE

Please check the box if any of the following diseases are common **in your family** or have occurred in any family member.

□ Allergies	□ Cancer	□ Diabetes	□ Migraines
□ Asthma	□ Heart Disease	□ Hearing Loss	□ Other:
□ Autoimmune Disease	□ Stroke	□ Bleeding Disorder	_____

Social History:

Tobacco Use: _____ Yes _____No Usage: <1 pack/day 1 pack/day >1 pack/day

Alcohol Consumption: _____ Yes _____No Daily 1-2 drinks/week 1-2 drinks/month 1-2 drinks/year

History of Substance Abuse: _____ Yes _____No If yes, specify: _____

Recreational Drugs: _____ Yes _____No If yes, specify: _____

Patient or Parent Signature:_____ Date: _____