PATIENT NAME_________________________________ DATE ______________________

PLEASE CIRCLE YOUR MAIN SYMPTOM, MEDICAL PROBLEM, OR REASON FOR THIS VISIT:

COUGH
DIZZINESS
DRAINAGE FROM EARS
EAR ACHE
FEVER
HEADACHE
HEARING LOSS
HOARSENESS
RASH
RINGING IN EARS
RUNNY NOSE
SINUS DRAINAGE
SORE THROAT
STUFFINESS OF NOSE
SWOLLEN GLANDS
WATERY, ITCHING EYES

WHEN DID THIS PROBLEM BEGIN?

DESCRIBE PREVIOUS TREATMENT, IF ANY:

PAST HISTORY: NAME ALL MEDICATIONS NOW TAKEN FOR ANY REASON:

MY DRUG STORE NAME:

DRUG ALLERGIES OR SENSITIVITIES: LIST ANY DRUGS OR MEDICATIONS TO WHICH YOU ARE ALLERGIC:

NAME ALL PREVIOUS OPERATIONS: (with approximate date or year performed):

DISEASES: HAVE YOU HAD OR DO YOU HAVE (circle those applicable and comment):
ASTHMA, DIABETES, HEART DISEASE, TUBERCULOSIS, CANCER, HIGH BLOOD PRESSURE, SEIZURES, BLEEDING TENDENCY (free bleeder), OR BRUISE EASILY?

DO YOU HAVE ANY OTHER SIGNIFICANT ILLNESSES OR MEDICAL PROBLEM?

ANY FAMILY MEMBERS WITH CANCER, DIABETES OR HEART PROBLEMS?

LAST PHYSICAL EXAM ____
IMMUNIZATIONS UP TO DATE YES ____ NO ____
DID YOU EVER USE TOBACCO? __________________ HOW MUCH? ________________
ANY PREVIOUS SIGNIFICANT INJURIES? WHEN? (especially to the head, nose or ear)

PLEASE NAME YOUR PRIMARY PHYSICIAN: ____________________________________
WHO COMPLETED THIS FORM? PATIENT ____ PARENT ____ SPOUSE ____ OTHER ________

WHO REFERRED YOU FOR THIS VISIT? ____

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