_____ _____ _____ _____

Name Age Home Phone Work Phone

_____ - _____ _____ _____

Address City State Zip

How long have you lived in this area? _____ Year(s) Where were you born and raised? _____

HPI and ROS: Check The Symptoms You Have

1. Nose & Mouth	Mild	Moderate	Severe	5. Respiratory	Mild	Moderate	Severe
Nasal blockage, congestion				Chest of Throat Tightness			
Sneezing				Cough: Daytime; Night			
Runny Nose				Wheezing			
Itchy nose				Trouble Breathing			
Frequent Nose Bleed				Asthma			
Loss of smell				Cough or Wheezing with Exercise			
Mouth sores or Ulcers				Cough: Productive; Dry			
Have you had or now have Nasal Polyps [ ]Yes [ ] No				Bronchitis			

2. Sinus & Throat	Mild	Moderate	Severe	6. Eyes	Mild	Moderate	Severe
Sinus Pressure				Itchy Eyes			
Post Nasal Drainage				Burning Eyes			
Frequent Infections				Swelling of Eyelids			
Frequent sore throat				Eye Discharge: ❒ Watery ❒Thick			
Nasal Discharge: ❒ Clear ❒ Colored ❒ Bloody				Red Eye			

3. Skin	Mild	Moderate	Severe	7. Ears	Mild	Moderate	Severe
Itchy Skin				Hearing loss			
Hives				Earaches			
Eczema				Frequent Infections			
Dry/ Scaly:				Vertigo			
Location of problem(s): ❒ Face ❒ Arms ❒ Trunk							

4. Headaches: Check the ones that describe your symptoms: ❒ Pressure ❒ Throbbing ❒ Sharp

Location: ❒Over Cheeks ❒ Behind Eyes ❒ Back of Head ❒ Frontal ❒ Top of Head ❒ Over Nose

Duration: ❒ Less than an hour ❒ Many Hours ❒ Days Frequency: ❒ Daily ❒ Weekly ❒ Monthly

Associated Symptoms: ❒ Nausea ❒ Vomiting ❒ Blurred Vision ❒ Neck Pain ❒ Runny Nose ❒ Light bothers you ❒ Foods ❒ Cold Air ❒ Menses

- Check those factors that make your symptoms worse:
  ❒ Changes in Weather ❒ Cold Weather ❒ While Dusting ❒ Animals ❒ Mowing the lawn
  ❒ Strong Odors ❒ Tobacco Smoke ❒ Exercise ❒ Raking leaves

- Do your symptoms vary with the seasons? If Yes circle the month or months below:

  Dec. Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov.

- List all of the medications you are presently taking:

Medications	Dose and reason for taking
1.	
2.	
3.	
4.	
5.	
Immunization Status:	Last Tetanus Shot: _____

8. Environmental Survey

Question	Yes	No	Question	Yes	No
Do you have any pets? If yes, what kind _____			Do you smoke or have you smoked? If yes, for how long _____ Did you Quit?		
Are your pets ever indoors?			Do you have houseplants?		
Do your pets sleep in your bedroom?			Do you have wall to wall carpeting?		
Are you exposed to birds?			Are you exposed to tobacco smoke?		
Do you have drapes in bedroom?			Are you exposed to chemicals at work?		
Type of Bed: [ ] Mattress/Box Spring [ ] Water Bed [ ] Foam Mattress					
Type of Pillow: [ ] Feather [ ] Foam [ ] Polyester					

9. Family History - Match those that apply using one or more of the codes indicated:
F- Father **M**- Mother **C**- Your Children **B**- Brother **S**- Sister **G**- Grandparents

_____ Asthma _____ Sinusitis _____ Food Allergies _____ Hay Fever _____ Diabetes

_____ Hives _____ Eczema _____ Glaucoma _____ High Blood Pressure

Are you allergic to any medications? _____
When you had reaction: ❑ Child ❑ Adult _____ years ago. **Symptoms:** ❑ Rash ❑ Hives ❑ Cough ❑ Anaphylaxis ❑ Shortness of Breath ❑ Stomach Ache ❑ Swelling

Are you allergic to any foods? _____
When you had reaction: ❑ Child ❑ Adult _____ years ago. **Symptoms:** ❑ Rash ❑ Hives ❑ Cough ❑ Anaphylaxis ❑ Shortness of Breath ❑ Stomach Ache ❑ Swelling

Are you allergic to insect stings? ❑ Yes ❑ No _____
Have you experienced rashes or trouble breathing from insect stings? ❑ Yes ❑ No
Usual amount of alcoholic beverages _____ Daily _____ Weekly
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widow

Current Occupation: _____ **Hobbies:** _____

10. Review of Systems – Other past and present medical conditions –

❑ Heart Problems	❑ Thyroid Disease	❑ Cancer	❑ TB
❑ High Blood Pressure	❑ Respiratory Illness	❑ Migraine	❑ Diabetes
❑ Liver Disease	❑ Kidney/Bladder Problems	❑ Glaucoma	❑ Depression
❑ Heart Arrhythmia	❑ Congestive Heart Failure	❑ Frequent Steroid Shots	
_____	_____	_____	_____
_____	_____	_____	_____

Past Surgeries? ❑ Tonsils ❑ Adenoids ❑ Nose ❑ Sinuses ❑ Heart ❑ Gall Bladder ❑ Hysterectomy ❑ Breast ❑ Prostate

Other Surgeries: _____
Hospitalization/Emergency Room Visits: When? _____ For? _____
When? _____ For? _____
Have you seen an ENT or Pulmonary doctor in the last three year? ❑ Yes ❑ No
Who is your primary care doctor: _____

Dr. Only: I have reviewed pages 1 & 2 with the patient _____