

Name _____ Age _____ Home Phone _____ Work Phone _____
 Address _____ City _____ State _____ Zip _____

How long have you lived in this area? ____ Year 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 or 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: <input type="checkbox"/> Watery <input type="checkbox"/> Thick			
Nasal Discharge: (✓) <input type="checkbox"/> Clear <input type="checkbox"/> Colored <input type="checkbox"/> 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): <input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> 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 your 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: <input type="checkbox"/> Mattress/Box spring <input type="checkbox"/> Water bed <input type="checkbox"/> Foam mattress					
Type of pillow: <input type="checkbox"/> Feather <input type="checkbox"/> Foam <input type="checkbox"/> 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 –

- | | | | |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> TB |
| <input type="checkbox"/> High blood Pressure | <input type="checkbox"/> Respiratory Illness | <input type="checkbox"/> Migraine | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney/bladder Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart arrhythmia | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> 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 last three years? Yes No

Who is your primary care doctor: _____

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