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Answering all questions as completely as possible will help to avoid any delay at your scheduled visit.

Patient's Name _____ Date of Birth ___/___/___ Appt. date ___/___/___

What problems would you like to address at your appointment?

Medication Allergies

_____ No known drug allergies

Allergic to: Drug name	Reaction	Date
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____

Food and Environmental Allergies

_____ No previous allergy testing
_____ Negative allergy testing by Dr. _____ Date _____
_____ Allergic to: FOOD _____ Reaction _____ Date _____
_____ Allergic to: Dust, Mold, Pollen _____ Reaction _____ Date _____
_____ Allergic to: Other _____ Reaction _____ Date _____

All Medications Taken Daily or as Needed (prescriptions, over the counter, herbal, vitamins) use additional sheet if needed

Name of Drug	Dosage	Taken how often?	Name of Drug	Dosage	Taken how often?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Has the patient taken any of the following medications in the past 14 days?

Aspirin? YES NO Date and amount of last dose _____

Ibuprofen/Advil/Motrin YES NO Date and amount of last dose _____

Pediatric Patients (please circle answer)

Is your child exposed to tobacco smoke? YES NO
Is your child in day care/ after school care/ mother's morning out? YES NO
Is your child's immunizations up to date? YES NO
Birth History _____

Adult Patients (please circle answer)

Do you smoke or chew tobacco? YES NO Number of packs per day _____
Alcohol Intake? YES NO How often? _____
Recreational drug use? YES NO How often? _____

Patient Name _____ Date of Birth ___ / ___ / ___ Appt. date ___ / ___ / ___

Weight _____ Height _____

Does the patient or any family member have any of the following medical problems or chronic illnesses?

Patient has complained of: (please circle the symptom)

Family Member Has:

NO	Loss of peripheral vision/ double vision/ vision loss Glaucoma	EYES	Glaucoma / Other Who:
NO	Hearing Loss / Ear Pain/ Vertigo / Ringing in the ear Nasal congestion or obstruction/ Sinusitis/ Allergies Other:	ENT	Hearing Loss /Ear infections /Allergies Who:
NO	Sore Throat/ Snoring/ Sleep Apnea/ Halitosis Dentures/ Cancer Other:	Mouth/Throat	Sleep Apnea/ Cancer Who:
NO	Swelling of hands-feet/ Heart murmur/ Arrythmia Fainting/ Heart Attack/ Angina/ VSD/ ASD/ Hypertension	Heart	Heart Murmur/ Heart Attack/ VSD/ ASD Arrythmia Who:

NO	Coughing phlegm or blood/ Dry Cough/ Asthma/ Wheezing/ Shortness of Breath/ Emphysema/ Tuberculosis	Respiratory	Emphysema/ Asthma/ Tuberculosis/ Cancer Who:
NO	Indigestion/ Heartburn/ GERD/ Blood in stool/ Diarrhea/ Constipation/ Abdominal Pain	Gastrointestinal	Cancer Who:
NO	Frequent or involuntary urination/ Painful urination/ Blood in urine/ Hepatitis	Genitourinary & Liver	Liver Cancer/ Bladder Cancer/ Kidney Cancer Who:
NO	Unexplained weight loss/ Loss of appetite/ Night sweats/ Fever/ Chills	Constitutional	

NO	Headaches/ Loss of coordination/ Seizure/ Paralysis/ Stroke/ Numbness or tingling	Neurological	Stroke/ Seizure/ Headaches Who:
NO	Depression/ Anxiety	Psychiatric	Mental Illness Who:
NO	Heat-cold intolerance/ Hair loss/ Excessive thirst/ Skin texture change/ Diabetes/ Thyroid problem Other:	Endocrine	Diabetes/ Thyroid problem/ Cancer Other: Who:
NO	Bleed excessively/ Easy bruising/ Anemia/ Swollen lymph nodes/ Lymphoma/ Leukemia	Hematologic or Lymphatic	Bleeding disorder/ Cancer Who:
NO	Arthritis/ allergy injections/ HIV/ AIDS	Allergy/Immune	Arthritis: Who

Please list any other serious illnesses or symptoms not mentioned above: _____

Please list any surgeries requiring general anesthesia (being put to sleep):

_____ Age _____
 _____ Age _____
 _____ Age _____
 _____ Age _____

Reviewed and accepted into Patient History:

by _____ Date _____