Name	Age	Home Phone	Work Phone	Cell 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	None	Mild	Moderate	Severe	4. Respiratory	None	Mild	Moderate	Severe
Nasal congestion					Chest or throat tightness				
Sneezing					Cough: Daytime; Night				
Runny nose					Wheezing				
Itchy nose					Trouble breathing				
Frequent nose bleeds					Asthma				
Loss of smell					Cough or wheezing with exercise				
Mouth sores or ulcers					Cough: Dry Productive: Clear				
Have you had or now have nasal polyps [ ] Yes [ ] No					Recurrent bronchitis				

2. Sinus & Throat	None	Mild	Moderate	Severe	5. Eyes	None	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 ❒ Thick ❒ Colored ❒ Bloody					Red Eye(s)				

3. Skin	None	Mild	Moderate	Severe	6. Ears	None	Mild	Moderate	Severe
Itchy skin					Hearing loss				
Hives					Earaches				
Eczema					Frequent Infections				
Dry/Scaly:					Vertigo				
Location of problem(s): ❒ Face ❒ Arms ❒ Trunk ❒ Extremities					Congestion				

7. Headaches: (✓) Check the ones that describe your symptoms: ❒ Pressure ❒ Throbbing ❒ Sharp ❒ Migraines

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

8. GI Symptoms: **Indigestion** ❒ Yes ❒ No **Heartburn** ❒ Yes ❒ No **Upset Stomach** ❒ Yes ❒ No

- **(✓) Check those factors that make your symptoms worse.**

❑ Changes in weather ❑ Cold weather ❑ 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:

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

- **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:

9. 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, how long? ____ (yrs) When did you quit? ____(yrs)		
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 your bedroom?			Are you exposed to chemicals at work?		
Type of bed: [ ] Mattress/Box spring [ ] Water bed [ ] Foam mattress					
Type of pillow: [ ] Feather [ ] Foam [ ] Polyester					

10. 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? **If yes, please list:**

If yes, when did you have the reaction? ❒ Child ❒ Adult ____years ago. **Symptoms:** ❒ Rash ❒ Hives ❒ Cough ❒ Anaphylaxis ❒ Shortness of breath ❒ Stomach ache ❒ Swelling

Are you allergic to any foods? **If yes, please list:**

If yes, when did you have the 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 hives or trouble breathing from insect stings? ❒ Yes ❒ No

Usual amount of alcoholic beverages: _____ Daily _____ Weekly_____ Occasionally

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	❒ Migraines	❒ Diabetes
❒ Liver disease	❒ Kidney/bladder problems	❒ Glaucoma	❒ Depression
❒ Heart arrhythmia	❒ Congestive heart failure	❒ Frequent steroid shots	❒ Reflux

Past surgeries? ❒ Tonsils ❒ Adenoids ❒ Nose ❒ Sinuses ❒ Heart ❒ Gall bladder ❒ Hysterectomy ❒ Breast ❒ Prostate

Other surgeries:

Hospitalization/Emergency Room Visits: When?_____ What for? _____

When?_____ What for? _____

Have you seen an ENT or pulmonary doctor in last three years? ❒ Yes ❒ No

Who is your primary care doctor?

Patient _____ **Date of Birth** _____