INITIAL HISTORY FORM

Patient name:_____**DOB**:_____

Main reason for today's visit (Describe briefly the illess and its duration):

Present Medications(including the strength and frequency):
(Include over-the-counter medications also):

Allergies to Medications: Yes__ or No___
If yes, list:

Symptoms Review:

Circle any of the following symptoms you are experiencing now or in the recent past:

Ears: pain, drainage, stuffiness, hearing loss, ringing, dizziness
Nose and Sinuses: Headache, Facial pressure or pain, Pressure around/behind eyes, nose bleed, nasal discharge, postnasal drip, nasal stuffiness & obstruction, snoring, cough, poor smell and taste , excessive sneezing, Itching inside nose, eyes, Red eyes, etc.
Throat: sorethroat, hoarsenss, difficulty swallowing, Bleeding from mouth/throat
General: Loss of weight, poor appetite,fatigue, fever, chills, night sweats
Skin: rashes, hives, easy bruising
GI: heartburn, belching, nausea, vomiting,diarrhea, constipation
Cardiovascular: chespain, palpitation, swollen feet
Resp: cough, wheezing, shortness of breath, daytime sleepiness, snoring
Neuro: blurred visin, double vision, slurred speech, weakness, tingling or numbness of face or extremities
GU: Frequent urination, burning urination, blood in the urine,

Past Medical Conditions:

(Circle any of the following medical conditions diagnosed at present or in the past):

Diabetes, High Blood Pressure, Heart problem, Lung problem, asthma, Kidney failure, Bleeding or coagulatin disorder,TB, Hepatitis, glaucoma, seizures, stroke, etc.
Any other medical diagnosis:_____

Previous Surgical Procedures: Yes___No___

If yes, list the name and date of the Procedure starting from the most recent:

Hospitalization in the past: Yes__No___

If yes, list the diagnosis and date starting from the most recent

Social History:

Tobacco(Smoke)including in the past: Yes___No___

If yes, how much and how long:_____

Tobacco(chew)including in the past: Yes___No___

If yes, how much and how long:_____

Alcohol use (including in the past): Yes___No___

If yes**,** what kind, how much and how long:_____

Substance abuse (including in the past) Yes___No___

If yes, give details:_____

Occupation:_____

Exposure to Noise(including in the past) Yes___No___

If yes, give details:_____

Any Pets at home: _____

Family History:

(Skip this if you are 65 and above)

Parents and their ages:_____

If deceased, at what age and what was the reason:

Siblings and their ages:_____

If deceased, at what age and what was the reason:

If any of the above persons and/or any other immediate blood relative have any of the following medical conditions:

Bleeding or coagulation disorder: Yes___No____

If yes, describe:_____

Cancer: Yes__No__

If yes, describe:_____

Hearing loss before the age of 25: Yes___No___

Any other significant medical condition: Yes___No____

If yes, describe: _____