Patient Name: _____ **DOB:**_____ **Date:**_____

What is the reason you are here today? _____

How would you prefer the doctor to address you? Mr. Ms. Mrs. Dr. First Name Nickname: _____

ALLERGIES? ☐ **No Allergies**

Medication Allergies	Type of Reaction		Medication Allergies	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No

Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone)_____

MEDICAL / SURGICAL HISTORY: **HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

☐ **No Medical / Surgical History**

Cardiovascular:		**Surgery/Management**
Coronary Artery Disease	☐	_____
Elevated Cholesterol (hyperlipidemia)	☐	_____
High Blood Pressure (hypertension)	☐	_____
Gastrointestinal:		
Hepatitis	☐	_____
Hernia	☐	_____
Gastroesophageal Reflux	☐	_____
Genitourinary:		
Prostate enlargement (Benign Prostate Hyperplasia)	☐	_____
Kidney Stones (Nephrolithiasis)	☐	_____
Renal Failure (Acute)	☐	_____
Ear / Nose / Throat: (HEENT)		
Cataracts	☐	_____
Glaucoma	☐	_____
Chronic Ear Infections (Otitis Media)	☐	_____
Hearing Loss	☐	_____
Sinus Problems (chronic sinusitis)	☐	_____
Nasal Polyps	☐	_____
Nasal Allergies	☐	_____
Recurrent Tonsillitis	☐	_____
Tinnitus	☐	_____
Vertigo	☐	_____
Hematologic :		
Anemia	☐	_____

Immunologic:		**Surgery/Management**
Allergies Type: _____	☐	_____
Food Allergies Type: _____	☐	_____
Infectious Disease:		
Mononucleosis	☐	_____
STD Type: _____	☐	_____
Metabolic/endocrine:		
Diabetes Type: _____	☐	_____
Thyroid deficiency (hypothyroidism)	☐	_____
Thyroid excess (hyperthyroidism)	☐	_____
Neoplastic:		
Cancer Type: _____	☐	_____
Neurologic:		
Migraine	☐	_____
Obstetric:		
Pregnancy Date(s): _____	☐	_____
Psychiatric:		
Adjustment Disorder - Anxiety	☐	_____
Major Depression	☐	_____
Pulmonary:		
Asthma	☐	_____
COPD	☐	_____
Emphysema	☐	_____
Sleep Apnea	☐	_____
Tuberculosis	☐	_____

If YES to any of the above Diagnosis was surgery performed?

What_____ **Where/When**_____ **By Who**_____