PATIENT'S NAME		DOB:		
	PLEASE USE B	SLACK INK ONLY		
HEALTH MAINTENANCE:		- · · · · · · · · - · -		
f applicable, please provide most	t recent date (approximat	e month/year) and if test was not	rmal or a	bnormal:
R		Results		
Sammogram: Flexible Sigmoidoscopy:				
Colonoscopy:	Pneumon	-		
PAST MEDICAL HISTORY: (F	OR PATIENT ONLY)	Are you currently pregnant?	YES	NO
NONE	High Cholesterol	Otitis media	125	110
Allergies	Emphysema	Otosclerosis		
Anemia	ENT Syndromes	Seizure disorder		
Anxiety	GERD	Sleep apnea		
Asthma	Headaches, migraine			
Birth trauma	Headaches	Tinnitus		
Bleeding disorder	Hearing disorder	Vertigo		
Cancer	High Blood Pressure			
Chronic infection	Hyperthyroidism	Other:		
Cleft lip	Hypothyroidism	Other:		
Cleft palate	Micrognathia	Other:		
Coronary artery disease	Microtia	Other:		
Depression	Multinodular goiter	Other:		
Diabetes	Obesity	Other:		
	NONE			
SURGICAL HISTORY:	NONE			X/E A D
SURGERY	YEAR	4		YEAR
[.		4		
2		5 6		
FAMILY HISTORY: (For blood Allergies: Asthma:		GERD: Hearing disorder:		
Autoimmune disease:		Hypertension:		
Blood disorder:		Migraines:		
Cancer:		Obesity:		
Cardiovascular disease:		Kidney disease:		
Chronic otitis media:		Seizure disorder:		
Cleft lip/palate:		Sickle cell disease:		
Coronary artery disease:		Sleep apnea:		
Cleft palate:		Stroke:		
Deafness: :		Thyroid disorder:		
Depression:		Other		
Developmental delay:		Othor		
_				
	ent Former	Never Unknown		
Developmental delay: Diabetes: High cholesterol: SOCIAL HISTORY:		Other		
TOBACCO USAGE: Curre	ent Former	Never Unknown		
Type: Chaying	Cigar Cigarat	tas Dina Smala	lace	Couff
Units/day: # Vac	Cigai Cigaici irs Used:	ttes Pipe Smoke ed to Quit: Yes No	Vear an	Siluli i it :
		cu to Quit 165 NO	rear qu	uı
Passive smoke exposure:	res No			
ALCOHOLUSE, Dainte alacted	. Voc M-	Formarly If formation		
ALCOHOL USE: Drinks alcohol:	res No	rormerly if formerly, year o	վuit:	
Type: Beer Li	quor wine	Amount:		
Frequency: Daily	weekly Monthly	Yearly Occasionall	y R	arely
DECDEATIONAL PRINCETICA	CE.	E		
RECREATIONAL DRUGS USA				
STEROID DRUG USAGE:	_Current Former	Never		

EW OF SYSTEMS: (Please check all that apply currently for the patient) Name Reaction Chills Visual changes Pever Apnea during sleep Weight loss Shortness of breath Choking on iquids Choking on liquids Choking on liquids Choking on solids Palpitations Chost pain Choking on solids Palpitations Drozianess Constipation Drozianess Constipation Drozianess Constipation Drozianess Drozianess Constipation Drozianess Drozianess Constipation Drozianess Constipation Drozianess Drozianess Constipation Drozianes Drozianess Constipation Drozianes Constipation Drozianes Constipation Drozianes Drozianes Constipation Drozesion Drozesion Drozesion Drozianes Constipation Drozesion Drozianes Constipation Contested this medical history form and, to the best of my knowledge, it is complete and accurate. I und	<u>HT</u> :	WEIGHT:		OCCUPATION:		
Name Dose Frequency	FERRED PHARMA	<u>CY</u> :				
VIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Patigue Hearing loss Weight loss Shortness of breath Non-restorative sleep Nourbest pain Non-restorative sleep Numbness in extremities Night sweats Wheezing Shortness Neight os Shortness Officulty staying asleep Excessive daytime sleepiness Non-restorative sleep Numbness in extremities Night sweats Wheezing Shortness Nees pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting Hoarseness Changes in urine color Mouth ulcers Holiculty with urination Ear pain Urinary frequency Sore throat Ringing in ears Heat intolerance Vertigo Increased thirst Vex completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under	DICATIONS:	None	List attached			
Name Dose Frequency	ease make sure to inclu	de over-the-counter	r medications, vitam	ins and herbal	remedies)	
VIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Diziziness Constipation Depression Drooling Diarrhea Hallucinations Drooling Diarrhea Hallucinations Drooling Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Weeting MR Nowledge, it is complete and accurate. I und We completed this medical history form and, to the best of my knowledge, it is complete and accurate. I und	Name	Do				
LERGIES - Please list any allergies below (including allergies to latex or shellfish):						
VIEW OF SYSTEMS: (Please check all that apply currently for the patient)						
LERGIES - Please list any allergies below (including allergies to latex or shellfish): Name Reaction Chills						
VIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst Ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under						
VIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on sliquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst Ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under						
VIEW OF SYSTEMS: (Please check all that apply currently for the patient)						
Name Reaction Name Reaction Name Reaction Name Reaction Name Reaction Name N						
No known alle Name Reaction						
ALERGIES - Please list any allergies below (including allergies to latex or shellfish): Name Reaction CVIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills						
Name Reaction VIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst Ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under						
VIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst Wesewess Difficulty Indicated Increased I und Tremor OTHERS: OTHERS: Ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I und		any allergies below		to latex or she	<u>llfish):</u> No known aller	
VIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst Visual changes Difficulty form and, to the best of my knowledge, it is complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the cold in the complete and accurate. I under the cold in the cold i			Reaction			
VIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst Visual changes Difficulty form and, to the best of my knowledge, it is complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in the complete and accurate. I under the cold in					-	
CYIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thist or wisowedge, it is complete and accurate. I under the charge of the patients of the patients Difficulty is a patient or the patient of the patient					-	
CVIEW OF SYSTEMS: (Please check all that apply currently for the patient) Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under					-	
Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under					-	
Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under					-	
Chills Visual changes Difficulty falling asleep Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under						
Fatigue Hearing loss Difficulty staying asleep Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I und						
Fever Apnea during sleep Excessive daytime sleepiness Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I und						
Weight loss Shortness of breath Non-restorative sleep Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst Non-restorative sleep Numbness in extremities Syncope Syncope Numbness in extremities Numbness in extremities Syncope Numbness in extremities	_					
Weight gain Snoring Numbness in extremities Night sweats Wheezing Syncope Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I und						
Night sweats						
Blurred vision Chest pain Tingling Choking on liquids Heart murmur Tremor Choking on solids Palpitations Weakness Double vision Abdominal pain Anxiety Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst Tingling Tremor Trenor Tremor Tremor Tremor Tremor Tremor Tremor Tremor Tremor Trenor Tremor Trenor Tremor Tremor Tremor Tremor Trenor Tremor Trenor Treation T	_		~			
Choking on liquids	_					
Choking on solids						
Double vision						
Dizziness Constipation Depression Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under the state of the state of my knowledge, it is complete and accurate. I under the state of my knowledge, it is complete and accurate. I under the state of my knowledge, it is complete and accurate. I under the state of my knowledge, it is complete and accurate. I under the state of my knowledge, it is complete and accurate. I under the state of my knowledge, it is complete and accurate.						
Drooling Diarrhea Hallucinations Difficulty swallowing Heartburn Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under the complete and accurate in the complete and accurate. I under the complete and accurate in the complete and accurate. I under the complete and accurate in the complete and accurate.						
Ear drainage Vomiting OTHERS: Hoarseness Changes in urine color	Drooling					
Hoarseness Changes in urine color Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under the color of the complete and accurate. I under the color of the	Difficulty swallowing	Heartb	urn			
Mouth ulcers Difficulty with urination Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I under the complete and accurate in the complete and accurate in the complete and accurate.				OT	HERS:	
Ear pain Urinary frequency Sore throat Cold intolerance Ringing in ears Heat intolerance Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I und						
Sore throatCold intolerance			•			
Ringing in ears Vertigo Heat intolerance Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I und	-					
Vertigo Increased thirst ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I und						
ave completed this medical history form and, to the best of my knowledge, it is complete and accurate. I und						
	verugo	increas	seu mirst			
	ave completed this mad	ical history form as	nd to the best of me	knowledge #	is complete and accurate. I and	
at this document will be used for medical decision making and treatment. I hereby consent to treatment.						
	THE NEW CLOSE A PRINCE			DATE:		
THEN TO CACALA THE THE	ATIENT SIGNATURE			DATE		