PATIENT HISTORY FORM

PATIENT NAME_____ **DOB**_____ **AGE**_____ **GENDER**_____ **DATE**_____

NAME OF PARENT/GUARDIAN/CARETAKER_____

REFERRED BY_____ **PRIMARY PHYSICAN**_____

A. CHIEF COMPLAINTS/REASON FOR TODAY'S VISIT

- List each complaint and when it started.
  1._____
  2._____
  3._____
  4._____
  5._____

B. MEDICATIONS AND VITAMINS/SUPPLEMENTS ---- List medications the patient is currently taking.

☐ Check here if the patient is **NOT** taking **ANY** medications or vitamins/supplements.

1._____Strength_____Dose_____Frequency_____
2._____Strength_____Dose_____Frequency_____
3._____Strength_____Dose_____Frequency_____
4._____Strength_____Dose_____Frequency_____
5._____Strength_____Dose_____Frequency_____
6._____Strength_____Dose_____Frequency_____
7._____Strength_____Dose_____Frequency_____
8._____Strength_____Dose_____Frequency_____
9._____Strength_____Dose_____Frequency_____
10._____Strength_____Dose_____Frequency_____

- List medications the patient has used in the **past** for allergies or asthma.
  1. Antihistamines_____
  2. Nasal Sprays_____
  3. Inhalers_____
  4. Other_____

C. PATIENT HISTORY

- Check the following medical conditions the patient is experiencing or has experienced in the past.

☐ NO PREVIOUS MEDICAL HISTORY

___ Arthritis
___ Asthma
___ Autoimmune Disease
___ Broken Nose
___ Bronchitis
___ Chronic Cough
___ COPD
___ COVID-19 Infection
DATE_____
___ COVID-19 Vaccine
DATE &DOSE#_____
___Deviated Septum
___ Ear Infections
___ Eczema
___ Food Allergy
___GERD/Heartburn
___ Hay Fever
___ Headaches
___ Heart Disease
___High Blood Pressure
___ Hives
___ Meningitis
___ Nasal Surgery
___ Pneumonia
___ Psoriasis
___ Rash(es)
___ Seizures
___ Sinus Infections
___ Thrush
___ Thyroid Disease

PLEASE LIST ANY OTHER MEDICAL ISSUE NOT LISTED ABOVE

_____

_____

- **Allergies/Intolerances to medications or other substances.**

Please list the substance(s) the patient reacted to, what the reaction was, and when it occurred.

☐ NO KNOWN ALLERGIES TO DATE

1._____
2._____
3._____
4._____
5._____

- **List all past surgeries and hospitalizations**:

Date	Type of Surgery/Hospitalization	Reason(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

- **Allergy History** (Check all that apply)

-Pollen Allergy
(Are the patient's symptoms…?)
___Worse outdoors
___Worse on windy Days
___Worse on clear Days
___Worse outdoors in AM
___Worse with change in temperature
___Worse in warm or cool air
___Better indoors
___Better outdoors

-Dust Allergy
(Are the patient's symptoms…?)
___Worse indoors
___Better outdoors
___Worse at night
___Worse in cold weather
___Worse when sweeping
___Worse when dusting

-Mold Allergy
(Are the patient's symptoms…?)
___Worse outdoors in PM
___Worse on cool evenings
___Worse in low, damp places
___Worse mowing or playing in grass
___Worse on windy days

-Contact Allergy
(Are the patient's symptoms…?)
___Worse in certain rooms
-Which rooms...? _____
___Worse in basement
___Worse near a barn
___Worse around animals
-Which animals...? _____

-During what months does the patient have the above symptoms?

___Jan	___Feb	___March	___April	___May	___June
___July	___Aug	___Sept	___Oct	___Nov	___Dec

-During what months are the above symptoms the ***most*** severe?

___Jan	___Feb	___March	___April	___May	___June
___July	___Aug	___Sept	___Oct	___Nov	___Dec

-Are the patient's allergy symptoms…? ☐ constant ☐ intermittent

- **Antibiotic History**

How many times in the last year has the patient been prescribed an Antibiotic? _____
Most recent Antibiotic(s)? Name(s)_____ Date(s)_____
How long did the patient use the antibiotic? _____
Why was an antibiotic needed? _____

PATIENT NAME_____ PATIENT DATE OF BIRTH _____

D. FAMILY HISTORY

- Circle all relatives with the following conditions:

1. Sinus Disease--	Father	Mother	Siblings	Children
2. Asthma--	Father	Mother	Siblings	Children
3. Allergies--	Father	Mother	Siblings	Children
4. Nasal Polyps--	Father	Mother	Siblings	Children
5. Eczema--	Father	Mother	Siblings	Children
6. Immune Disease--	Father	Mother	Siblings	Children

7. List any other family history of Thyroid problems, Lupus, Rheumatoid, etc.

_____

_____

E. SOCIAL INFORMATION

- **Smoking:** ☐ Nonsmoker ☐ Current ☐ Former
  Is the patient exposed to **second-hand smoke**? ___Yes ___No
  If the patient is a **current** or **former smoker**, **how often/how much**…? _____
  What substance(s)…? ☐ Tobacco Products ☐ Marijuana ☐ Vape Products
  Years smoked_____ Quit smoking in_____
- **If the patient is a child**:
  Who do they live with? _____
  Grade in school_____ # of days of school missed during current/previous school year? _____
  If in daycare, # of children in daycare_____
- **Living arrangements:**
  Who lives in the patient's home _____
  What pets are in the patient's home _____
  Occupation_____ Patient is retired ☐ Number of children? _____
- **Home arrangements:**
  Type of home: ____House ___ Apartment ___ Slab Foundation ___ Basement

  Heating/Ventilation:
  ___Forced Air Heat (Radiator/Baseboard) ___ Radiant Heat (Emanating Floor Heat)
  ___ Central AC ___ Wood Burning Stove ___ Ceiling Fans ___ Window AC ___ Floor Fans

  Patient's Bedroom: Are there any…?
  ☐ Stuffed animals ☐ Books ☐ Clutter ☐ Clothing

  Flooring:
  ___ ***Wood Flooring*** -- Which areas of the home…?
  ___Master Bedroom ___Children's Bedroom ___Bathroom ___ Kitchen
  ___Living Room ___ Family Room ___ Office ___ Foyer/Entryway/Hall

  ___ ***Carpet*** -- Which areas of the home…?
  ___Master Bedroom ___Children's Bedroom ___Bathroom ___ Kitchen
  ___Living Room ___ Family Room ___ Office ___ Foyer/Entryway/Hall
  How old is the carpet? _____years

  ___ ***Vinyl/Tile*** -- Which areas of the home…?
  ___Master Bedroom ___Children's Bedroom ___Bathroom ___ Kitchen
  ___Living Room ___ Family Room ___ Office ___ Foyer/Entryway/Hall

F. SYSTEMS REVIEW/SYMPTOMS (CHECK ALL THAT APPLY)

- *General*

___Weakness ___Change in appetite ___Chills
___Fatigue ___Fever ___Night sweats
___Sleep Disturbance

- *Eyes*

___Blurred Vision ___Discharge ___Itching
___Watery ___Red eyes

- *Ears, Nose, and Throat*

___Nasal Congestion ___Change in sense of smell ___Change in sense of taste
___Nasal Itch ___Jaw Pain/TMJ ___Bad Breath
___Foul taste ___Sore Throat ___Mouth Breather
___Snores ___Hard of hearing ___Muffled Hearing
___Ear Fullness ___Ear Pain ___Nasal Discharge
___Sneezing ___Ear Itching ___Sinus Pain
___Sinus pressure ___Dental Pain

- *Endocrine*

___Hot/Cold Intolerance ___Hair Loss/Gain ___Irregular Menstrual Cycle
___Weight Gain ___Weight Loss

- *Respiratory*

___Shortness of Breath is worse when laying down ___Cough
___Shortness of Breath at rest ___Shortness of Breath w/ exertion
___Increased Sputum Production ___ Wheezing

- *Intestinal*

___Constipation ___Diarrhea ___Trouble Swallowing
___Heartburn ___Nausea ___Vomiting

- *Skin*

___Frequent Bruising ___Swelling ___Hives
___Itching ___Rash

- *Neurological*

___Dizziness ___Lightheadedness ___Headaches

- *Psychiatric*

___Anxiety ___Depressed Mood

G. ANY OTHER INFORMATION PERTINENT TO YOUR VISIT…?

_____

_____

_____

_____