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Patient Name: _____ **Date:** _____

Chief Complaint

1. Why are you here to see the Doctor? Please list in order of importance:

   a. _____ b. _____

   c. _____ d. _____

2. Is this visit work related? □ YES □ NO

Review of Systems: Review the list below and "X" the box that describes a current problem and line through "/" those you have frequently had in the past.

For Internal use & Billing (= Problem Focused – 0; EPF problem pertinent system: Detailed – 2-9 systems; Comprehensive 10+ systems)*

***General:**	□ Chills	□ Fever	□ Thyroid Problems	□ Weight Loss
	□ Weight Gain	□ Decrease in Appetite		
***HEENT:**	□ Itchy Throat	□ Throat Closing	□ Excessive Sputum or phlegm	□ Change in Voice
□ Headache	□ Itchy Eyes	□ Difficulty with Vision	□ Double Vision	□ Dark Circles Under Eyes
□ Ear Pressure	□ Ear Infection	□ Difficulty Hearing	□ Ringing in Ears	□ Ears Popping
□ Deafness	□ Trouble Smelling	□ Nasal Congestion	□ Nasal Drainage	□ Post Nasal Drip
□ Deviated Septum	□ Frequent Colds	□ Excessive Sneezing	□ Sinus Pressure	□ Trouble Breathing Through Nose
□ Nose Bleeds	□ Trouble Tasting	□ Tongue Swelling	□ Mouth Sores	□ Frequent Throat Clearing
□ Hoarseness	□ Bad Breath	□ Mouth Breathing		
***Pulmonary:**	□ Coughing Spells	□ Tightness in Chest	□ Wheezing	□ Shortness / Nighttime Shortness of Breath
	□ Difficulty Breathing		□ Coughing Up Blood	
***Cardiac:**	□ Chest Pain	□ Palpitations	□ Heart Attacks	□ High Cholesterol
	□ Swelling in Feet or Ankles	□ Swelling of Legs	□ Excessive Sweating	□ Murmur
	□ High Blood Pressure	□ Mitral Valve Prolapse		□ Heart Failure
***Gastrointestinal:**	□ Heartburn	□ Indigestion	□ Hiatal Hernia	□ Gas
□ Belching	□ Cramping	□ Gall Stones	□ Chronic Nausea	□ Trouble Swallowing
□ Vomiting	□ Lip/mouth tingling after eating certain foods	□ Chronic Diarrhea	□ Chronic Constipation	□ Vomiting Blood
□ Blood in Bowel Movements	□ Black or Loose Bowel Movements	□ Stomach Ulcers	□ Stomach Pain	□ Hemorrhoids
***Nephrological:**	□ Frequent Urination	□ Urination in Evening	□ Painful Urination	□ Discolored Urine
	□ Kidney Stones	□ Reduction in Force of Urine	□ Difficulty Starting Urination	□ Leakage in Urine
	□ Blood in Urine	□ Enlarged Prostate		
***Musculoskeletal:**	□ Back Pain	□ Muscle Cramping	□ Arm or Leg Pain	□ Pain in Legs While Walking
	□ Joint Swelling	□ Joint Pain	□ Pain with Cold Weather	
***Neurological:**	□ Dizziness	□ Seizures	□ Numbness in Hands, Feet or Legs	□ Difficulty Maintaining Balance
	□ Fainting/Blackout Spells	□ Strokes	□ Change in Facial Appearance	
***Endocrinological:**	□ Chronic Fatigue	□ Prefer Hot Weather	□ Prefer Cold Weather	□ Breast Discharge
□ Lumps in Breast	□ Painful Breast	□ Irregular Menses	□ Vaginal Itching	□ Frequent Yeast Infections
***Dermatological:**	□ Skin Rash	□ Hives	□ Itching of Skin	□ Dry Skin
	□ Increase of Oiliness of Skin	□ Skin Paleness	□ Eczema	□ Blisters
	□ Psoriasis	□ Reaction to Lotions	□ Reactions to Cosmetics	□ Reactions to Chemicals
***Hematological:**	□ Bruise Easily	□ Excessive Bleeding		
***Psychological:**	□ Crying Spells	□ Nervousness	□ Depression or Anxiety	□ Difficulty Sleeping
***Sleep Apnea Screening:**	□ Snoring	□ Wake Up Fatigued		□ Fatigued Throughout the Day

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Past Medical History

Hospitalizations: _____

Surgical History: _____

ER Visits: _____

Medical Illnesses / Disease: _____

_____

Miscellaneous: have you ever had collagen / silicone implants? ☐ YES ☐ NO

Have you had metal joints / parts surgically placed in your body? ☐ YES ☐ NO

Where? _____ When? _____

Drug Allergies: ☐ N/A ☐ Penicillin ☐ Aspirin ☐ Sulfa ☐ Dye ☐ Others

Adverse Food Reactions: _____

Latex Sensitivity: _____

Recent Dental Work: ☐ None ☐ Type _____ ☐ Any Adverse Reactions? ☐ Yes ☐ No

Contact Sensitivity: ☐ None ☐ Elastics ☐ Bandages ☐ Nickel ☐ Others _____

Insect Stings: ☐ N/A ☐ Large Swelling ☐ Itching all over body ☐ Rash all over body ☐ Wheezing ☐ Shortness of Breath

Vaccination Status: ☐ Childhood ☐ Current ☐ Other: _____

Last Flu Shot: _____ (Year) Last Pneumonia Shot: _____ (Year)

Past Allergy Therapy / Testing

Have you had / or are you currently on allergy shots? ☐ YES ☐ NO

Did you have any reactions to the shots? ☐ YES ☐ NO Did the shots help? ☐ YES ☐ NO

Allergist Name & Address: _____

_____

Immunotherapy: Q_____ Dilution: _____

☐ No Reactions ☐ Reactions: _____

Medications

List all the medications you are now taking (Prescriptions, over the counter, eye-drops, nasal sprays, vitamins, "natural products," supplements, herbs, etc…)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Past Family History

Who in Your Family Had	Self	Father	Mother	Sister(s)	Brother(s)
Migraines					
Hives					
Hay Fever					
Sinus Problems					
Glaucoma					
Emphysema					
Asthma					
Cystic Fibrosis					
Tuberculosis					
Thyroid Disease					
Heart Attack					
Stroke					
High Blood Pressure					
Cancer					
Others					

Past Social History (give parent's status if patient is a child)

Marital Status: _____ Current occupation: _____

Education: Grade School (Highest Grade___) High School □ 1 □ 2 □ 3 □ 4 College □ 1 □ 2 □ 3 □ 4 Other: __

Hobbies: _____

Smoker: □ N/A □ Cigarette □ Cigar □ Pipe Number Per Day _____ How Long _____ Stopped Smoking ___

Are you exposed to smoke? □ At Home □ At Work □ Socially

Drug Use: □ N/A □ Marijuana □ Heroine □ Cocaine □ Body Building Steroids □ Recreational Drugs

How Often? _____

Alcohol Intake: □ N/A Average Per Day _____ Type: □ Liquor □ Beer □ Wine

Environmental History

Home/ Dwelling: Age: _____ Style: □ Condo/Apt □ Cement Block □ Wood House □ Mobile □ Boat

Length of Occupancy: _____ How long have you lived in this part of Florida? _____

Type of Heating: □ Central □ Radiator Type of Air Conditioning: □ Central □ Window

Humidifier: □ Central □ Separate Units Water: □ City □ Well

Bed: □ Foam □ Waterbed □ Air Mattress □ Innerspring (age_____)

Pillow: □ Feather □ Foam □ Dacron □ Polyester (Age____)

Comforter: □ Feather □ Non-Feather

Flooring: Living Area: □ Carpet □ Tile □ Wood Bedroom: □ Carpet □ Tile □ Wood

Type of Pets: _____ □ Inside □ Outside Roaches: □ YES □ NO

Indoor Plants: □ YES □ NO Do you have any concerns with environment at home or work? □ YES □ NO

Disease Impact on Function: _____

I have reviewed the above patient information sheet with the patient/family member.

_____

Clinician

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