

# Patient Information | Personal Health History Form

This form will be part of your medical record. Upon completion, please sign the last page. All history is held strictly confidential and is released only with your written permission.

Last Name	M.I.	First Name	Date Of Birth 00-00-0000	Age
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of your primary physician			How did you hear of our clinic? (check all that apply)	
<input type="text"/>			<input type="radio"/> Internet Search	
<input type="radio"/> No Primary Physician			<input type="radio"/> Previous Patient	
In your own words, what is the reason for your visit?			<input type="radio"/> Referral from Doctor	
<input type="text"/>			<input type="radio"/> Insurance List	
			<input type="radio"/> Seen on TV	
			<input type="radio"/> Commercial	
			<input type="radio"/> Magazine/Newspaper	
			<input type="radio"/> Sign	

<b>Check if you have these symptoms:</b> (check all that apply)	<b>How often do you have sinusitis (facial pain/pressure)?</b>	<b>Are you are having difficulty using your CPAP machine?</b>
<input type="radio"/> Snoring	How many times per year?	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Mouth breathing	<input type="text"/>	
<input type="radio"/> Stop breathing at night	<input type="radio"/> constantly	<b>Why are you having problems using your CPAP machine?</b>
<input type="radio"/> Daytime tiredness	<input type="radio"/> never	<input type="radio"/> Not a problem
<input type="radio"/> Gasping at night		<input type="radio"/> Claustrophobic
<input type="radio"/> Weight Gain	<b>How have you treated your sinus infections?</b> (check all that apply)	<input type="radio"/> Rash/irritation from mask
<input type="radio"/> Nasal Obstruction	<input type="radio"/> Antibiotics	<input type="radio"/> Travel
<input type="radio"/> Sneezing	<input type="radio"/> Nasal Steroid Sprays (eg., Nasonex™)	<input type="radio"/> Pull mask at night
<input type="radio"/> Runny Nose	<input type="radio"/> Nasal Decongestants (eg., Afrin™)	<input type="radio"/> Leaks
<input type="radio"/> Post nasal drip	<input type="radio"/> Salt Water Sprays	
<input type="radio"/> Watery or itchy eyes	<input type="radio"/> Decongestants	<b>Check any ENT procedures you have had in the past.</b>
<input type="radio"/> Nose bleeds	<input type="radio"/> Antihistamines	<input type="radio"/> Tonsillectomy or Adenoidectomy
<input type="radio"/> Loss of smell		<input type="radio"/> Septoplasty
<input type="radio"/> Pressure in the head/sinus	<b>Have you had a sleep Study?</b>	<input type="radio"/> Sinus Surgery
<input type="radio"/> Headaches	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> UP3 (sleep apnea surgery)
<input type="radio"/> Dizziness/Vertigo	(If yes, please obtain the study or call our office so we may obtain the study for you)	<input type="radio"/> Rhinoplasty
<input type="radio"/> Ear drainage		<input type="radio"/> Voice Box (Larynx) Surgery
<input type="radio"/> Ear fullness or pressure	<b>Were you recommended a CPAP machine?</b>	<input type="radio"/> Ear (Myringotomy) Tubes
<input type="radio"/> Ear pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Other Ear Surgery
<input type="radio"/> Noise or ringing in the ears		<input type="radio"/> Thyroidectomy
<input type="radio"/> Worsening hearing		
<input type="radio"/> Heartburn		
<input type="radio"/> Fever		
<input type="radio"/> Bad breath		
<input type="radio"/> Hoarseness		
<input type="radio"/> Difficulty swallowing		
<input type="radio"/> Dry mouth		
<input type="radio"/> Difficulty in breathing		
<input type="radio"/> Unexplained weight loss		

<b>Check any conditions that you have or have had in the past.</b>	<b>Does anyone in your family have any of the following?</b>	<b>Could you be pregnant (women in childbearing years)?</b>
<input type="radio"/> AIDS/HIV	<input type="radio"/> Cancer	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Epilepsy (seizure)	What type? <input type="text"/>	
<input type="radio"/> Multiple Sclerosis	<input type="radio"/> Allergies	<b>List all prescription and non-prescription medications you currently take:</b>
<input type="radio"/> Alcoholism	<input type="radio"/> Diabetes	<input type="radio"/> None
<input type="radio"/> Gastroesophageal Reflux	<input type="radio"/> Thyroid disease	List medications <input type="text"/>
<input type="radio"/> Peptic ulcer disease	<input type="radio"/> Bleeding disorders	
<input type="radio"/> Anemia	<input type="radio"/> Heart disease	<b>Do you take Aspirin, Coumadin, Plavix, or other blood thinners?</b>
<input type="radio"/> Goiter	<input type="radio"/> Problems with anesthesia	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Pneumonia/Bronchitis	<input type="radio"/> Sleep apnea	
<input type="radio"/> Anxiety/Panic Attacks	<input type="radio"/> Hearing Loss	<b>Do you take diet pills?</b>
<input type="radio"/> Heart disease (heart attack, CHF)		<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Psychiatric Care	<b>Do you have any other medical conditions?</b>	
<input type="radio"/> Arthritis	<input type="text"/>	<b>What medications are you allergic to or have had bad reactions?</b>
<input type="radio"/> Hepatitis or liver disease		<input type="radio"/> None
<input type="radio"/> Rheumatic Fever	<b>Have you had any other surgeries or procedures?</b>	List medications <input type="text"/>
<input type="radio"/> Asthma	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> High blood pressure	Explain if answered yes	
<input type="radio"/> Scarlet Fever	<input type="text"/>	
<input type="radio"/> Bleeding disorder		
<input type="radio"/> High cholesterol		
<input type="radio"/> Syphilis		
<input type="radio"/> Chemical Dependency		
<input type="radio"/> Immune deficiency		
<input type="radio"/> Sleep apnea		
<input type="radio"/> Depression		
<input type="radio"/> Kidney disease		
<input type="radio"/> Stroke		
<input type="radio"/> Diabetes		
<input type="radio"/> Lung disease		
<input type="radio"/> Thyroid disorder		
<input type="radio"/> Emphysema		
<input type="radio"/> Migraines		
<input type="radio"/> Tuberculosis		
<input type="radio"/> Cancer		
What type? <input type="text"/>		

<b>Do you smoke?</b>	<b>Have you or currently used any "street drugs"?</b>	<b>Do/have you drink alcohol?</b>
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> No
	What type? <input type="text"/>	<input type="radio"/> Socially
<b>Have you smoked in the past?</b>		<input type="radio"/> One glass of wine everyday
<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Heavy
How Long? (years/months) <input type="text"/>		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the office staff responsible for errors or omissions that I may have made in completing this form.

Date 00-00-0000

Last 4 digits of SSN