Patient Name: _____ Age: ____ Date: _____
CC: What problem are you here to have evaluated? _____
_____
HPI: Where is the problem? _____
Describe the problem _____Left/Right
How long have you had the problem? _____ How long does it last? _____
How severe is the problem? _____
When do you experience the problem? _____
What seems to change your symptoms? _____
What other symptoms or signs occur with the problem? _____
PMH: What serious illnesses or injuries have you had? _____
What surgery have you had? _____
What medications do you take now? Please give dosage _____
_____
Are you allergic to any medications? Please list _____
Family History: Are there any inherited diseases that occur in your family such as: diabetes, heart disease, problems with anesthesia, excessive bleeding, hearing loss or any other? Please circle or list: _____
Social History: ___married ___single ___other **Job**: _____**Education**:_____
Noise exposure: _____Do you use tobacco? _____ How much? _____
Do you use alcohol? _____ How often? _____
Have you used illegal drugs? _____ Have you been exposed to HIV? _____
Review of Medical Systems: Have you had any diseases that involve the following areas?
(Circle diseases, write any other problems in blanks, or check if normal)

Normal

Constitutional: Fever, weight loss, night sweats, _____ _____
Eyes: Loss of vision, cataracts, glaucoma, _____ _____
Ears, nose, throat, _____ _____
Cardiovascular: high blood pressure, chest pain, heart attack, irregular pulse, circulation problems: _____ _____
Respiratory: asthma, emphysema, chronic bronchitis, _____ _____
Gastrointestinal: reflux, ulcers, liver disease, nausea, _____ _____
Musculoskeletal: arthritis, osteoporosis, fibromyalgia, _____ _____
Skin/Breast: dermatitis, skin cancer, breast cancer, _____ _____
Neurologic: headache, migraine, stroke, TIAs, seizures, _____ _____
Psychiatric: depression, anxiety disorder, _____ _____
Endocrine: diabetes, thyroid disease, _____ _____
Hematologic: anemia, bleeding disorder, sickle cell disease, _____ _____
Allergic/immunologic: allergies, hay fever, autoimmune disorder, _____ _____
Cancer, _____ _____
Other comments or problems, _____
_____

Patient or Parent Signature: _____ M.D Initial _____