





Name: \_\_\_\_\_

Appt. Date: \_\_\_\_\_

**To be completed by patient.**

**Check the following medical conditions that you have currently or have had in the past.**

	Current	Past
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Polyps	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Croup	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Gastroesophageal Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Colitis or Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
_____		
_____		

**Please list all hospitalizations (including year and reason)**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

**To be completed by physician.**

**Physical Exam:**

WT: \_\_\_\_\_ HT: \_\_\_\_\_

T: \_\_\_\_\_ P: \_\_\_\_\_ BP: \_\_\_\_\_

**General Appearance:**

**EYES:** CONJUNTIVA- NORMAL R L ; RED R L  
LIDS- NORMAL R L ; EDEMA-

**EARS:** TMS- NORMAL R L ; DULL R L ; RED R L  
CANALS- NORMAL OCCLUDED

**NOSE:** MUCOSA- NORMAL PALE RED  
EDEMA- R- MILD MODERATE SEVERE  
L- MILD MODERATE SEVERE  
MUCOUS- MILD MODERATE COPIOUS  
SEROUS WHITE MUCOID

POLYPS- NONE ; PRESENT R L  
SEPTUM- MIDLINE ; DEVIATED R L  
EXCORIATED R L ; PERFORATED

**OROPHARYNX:** PALATE- NORMAL OTHER:  
POST PHARYNX- NORMAL INJECTED  
COBBLESTONED PND

**TEETH & GUMS:** NORMAL ; OTHER:

**FACE/SINUS TENDERNESS:**

ABSENT FRONTAL MAX

**NECK:** NORMAL APPEARANCE

**THYROID:** NORMAL ENLARGED

**LYMPHATICS:** NECK AXILLA GROIN

**CHEST:** VENTILATION- NORMAL RETRACTIONS

AUSCULTATION- NORMAL

WHEEZES R L BILAT FVC

RHONCHI R L BILAT

Patient \_\_\_\_\_  
Appt Date \_\_\_\_\_

**To be completed by patient.**

**For children under 15, complete the following:**

1. Birth Weight:
2. Were there any complications following delivery?     Yes     No  
Explain:
3. Has growth and development been normal?     Yes     No  
Explain:
4. Are immunizations up to date?  
 Yes     No

**Social History**

Current Occupation: \_\_\_\_\_

Marital Status:    **S**    **M**    **D**    **W**

Hobbies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cigarette Smoking History:

\_\_\_\_\_

**Environmental History:** (Please check the appropriate boxes.)

Home:     House     Apartment     Condo  
           Mobile Home    Age: \_\_\_\_\_

Pets:     Cat     Indoor     Outdoor  
           Dog     Indoor     Outdoor

Smokers:     None  
               Indoors By: \_\_\_\_\_  
               Outdoors By: \_\_\_\_\_

Heat:     Central     Radiator

Air conditioning:     Central     Window

Pillows:     Feather     Non-feather    Age: \_\_\_\_\_

Bed:     Mattress/Boxspring     Waterbed  
          Age: \_\_\_\_\_

Flooring:     Hardwood     Carpet    Age: \_\_\_\_\_

Basement or Crawlspace:

Dry     Damp     Musty

**To be completed by physician.**

**Physical Exam (continued):**

CVS: \*Heart-  
      \*PV(observ/palp)-

Abdomen:    \*Tenderness                    Mass  
              \*Liver/Spleen-    Normal    Enlarged

\*Extremities:

\*Skin:    Normal:    Other:

Neuro/Psych:    \*Orientation-

                  \*Mood/Affect-

Other:

\_\_\_\_\_  
PF:1-5    EPF:6-11    D:12    C:ALL

**Whom may we thank for referring you?**

- Physician Office      Name: \_\_\_\_\_
- Relative or Friend      Name: \_\_\_\_\_
- Insurance Provider Directory
- Yellow Pages
- Signage
- Other: \_\_\_\_\_