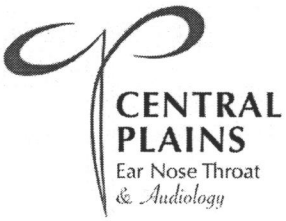

PATIENT NAME: _____DOB:_____

REFERRING MD: _____PRIMARY CARE:_____

HEIGHT: _____ WEIGHT: _____

FLU VACCINE: ____ DATE RECEIVED: _____ PNEUMONIA VACCINE: ___ DATE RECEIVED: _____

TOBACCO USE: _____PPD_____YEAR STARTED/QUIT_____
CHILDHOOD EXPOSURE: _____

ALCOHOL USE: _____
PRENATAL EXPOSURE: _____

FAMILY HISTORY: (ILLNESSES)
_____

SOCIAL HISTORY:

MARITAL STATUS: _____

PREGNANT: _____ CHILDREN:_____DAYCARE:_____

OCCUPATION: _____

PAST MEDICAL HISTORY:
_____
_____

PAST SURGICAL HISTORY:

_____
_____

MEDICATIONS: (STRENGTH & DOSAGE)

_____
_____
_____

ALLERGIES:
_____

REASON FOR VISIT: _____

REVIEW OF SYSTEMS:

EARS: Infections Pain Drainage Dizziness Hearing Loss Ringing

NOSE/ SINUS: Headaches Polyps Changes in smell Dryness Snoring
Congestion Drainage Nosebleeds

ORAL: Sore throat Mouth breathing Feeling of lump in throat

NECK: Hoarseness Difficulty swallowing

CONSTITUTIONAL: Fatigue Fever Change in weight ___LOSS ___GAIN

EYES: Itching Double vision Glaucoma Cataracts

RESPIRATORY: Chronic cough Asthma Shortness of breath Emphysema COPD

CARDIOVASCULAR: Heart disease Prolapsed valve High blood pressure
Extra beats Swelling in legs Heart attack

GI: Vomiting Diarrhea Heartburn/Reflux Constipation

NEUROLOGICAL: Numbness Paralysis Tremor Seizures Blackouts Trauma

ENDOCRINE: Diabetes Thyroid disease

SKIN: Rash Itching

MUSCULOSKELETAL: Pain in neck Pain in joints

URINARY: Kidney disease

PSYCHIATRIC/EMOTIONAL: Anxiety Depression ADHD ADD