

Who is your primary physician? _____
 What brings you to our office? _____

PAST HISTORY

Illnesses and treatments:

- | | | | | |
|--|---------------------------------------|--|------------------------------------|----------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> HIV / ARC | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Weight gain / loss >20% | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Arthritis / RA | <input type="checkbox"/> Apnea | |
| <input type="checkbox"/> Herpes/Cold sores | <input type="checkbox"/> Hepatitis | Other _____ | | |

Surgery: Please list dates.

- Tonsillectomy
- Septoplasty
- Sinus surgery
- Thyroidectomy
- Ear surgery
- Dental / Oral Surgery
- Other _____

- Hysterectomy
- Hernia
- Appendix
- Orthopedic
- Gall bladder

Cosmetic

- Botox
- Collagen/Radiance
- Chin Augmentation
- Blepharoplasty
- Rhinoplasty
- Facelift
- Browlift
- Abdomen
- Breast
- Liposuction
- Skin Resurfacing

Your family history:

- Diabetes
- Cancer
- Hypertension
- Anesthesia difficulty
- Bleeding
- Other _____

Are you:

- Married
- Single
- Divorced
- Widowed
- Disabled
- Student

Medications: Please list drug name and dosage.

- Diuretic _____
- Anti-Hypertensive _____
- Anti-Cholesterol _____
- Hormones _____
- Pain / Analgesia _____
- Sleeping _____
- Herbs (Kava, Ginko, Ginseng, Echinacea, Ephedra, Garlic, St.Johns Wart, Valerian)

HABITS

Do you currently use:

- | | | |
|--------------|---|---|
| Tobacco | Y | N |
| used in past | Y | N |
| Alcohol | Y | N |
| used in past | Y | N |

Do you:

- | | | |
|----------|---|---|
| Exercise | Y | N |
|----------|---|---|

Allergies: Please list reaction.

- | | |
|--|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine / Seafood |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Aspirin / Advil / NSAIDS |
| <input type="checkbox"/> Cipro/Levaquin | <input type="checkbox"/> Foods |
| <input type="checkbox"/> Erythromycin / Biaxin | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Narcotics | <input type="checkbox"/> Asthma |
| | Other _____ |

SYSTEM REVIEW

Do you have: please circle all that apply

- Ear** pain noise/tinnitus drainage hearing loss wax problem dizziness
Nose bleeding congestion loss of smell snoring apnea
Throat voice change difficulty breathing difficulty swallowing
Neck thyroiditis goiter enlarged lymph nodes
Skin rash cysts cancer

Have you had in the past?

- Cardiac** heart murmur hypertension Mitral Valve Prolapse
GI ulcer Acid reflux GERD Colitis Irritable bowel
GU frequent urination kidney stones
Neuro/Ortho rheumatoid arthritis MS lupus herniated disk

Would you like to know more about: please circle

- Apnea
- Snoring
- Nasal Congestion

- Skin Care
- Botox
- Collagen/Radiance
- Visage

- Voice problems
- Swallowing

SKIN CARE

Do you regularly use:

- | | | | |
|--------------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> sunscreen | <input type="checkbox"/> Masque | <input type="checkbox"/> Accutane | <input type="checkbox"/> Kinerase |
| <input type="checkbox"/> moisturizer | <input type="checkbox"/> Scrub/Peel | <input type="checkbox"/> Retin-A | <input type="checkbox"/> Copper Peptide |
| <input type="checkbox"/> cleanser | <input type="checkbox"/> Toner | <input type="checkbox"/> Glycolics | <input type="checkbox"/> Vitamin C |
- Do you sunburn? Y N Is you skin often red? Y N

Would you like to see our Esthetician about skin care and products? Y N