



**NEW PATIENT HISTORY
OREGON SINUS CENTER**

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Age: _____

Please answer all of the following questions to the best of your ability.

Please write N/A if the question is NOT applicable to you.

CLINICIAN
NOTES ONLY

CHIEF COMPLAINT:

What is the reason for this appointment? _____

HISTORY OF PRESENT ILLNESS:

Which of the following symptoms do you suffer?

- Nasal Obstruction Nasal discharge Headache Facial pressure/pain
 Decreased smell Bad breath Cough Fatigue

When did the problem(s) start? _____

Does anything make it better or worse? _____

Any other associated symptoms? _____

Have you been tested for allergies? Yes No When: _____ Results: _____

PAST MEDICAL HISTORY:

List the medicines you are taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List medical conditions you are/have been treated for (high blood pressure, diabetes, etc.) _____

List previous surgeries: _____

List drug allergies: _____

Do YOU have any of the following:

NO YES

- Asthma/Lung disease
 Arthritis
 Diabetes
 Excessive bleeding
 Fevers
 Heart Disease

NO YES

- Heartburn/Reflux
 Kidney disease
 Migraines
 Seizures
 Depression
 Stroke

SOCIAL HISTORY:

Your occupation: _____

Do you smoke/chew tobacco?

Yes No How much: _____

Do you drink alcohol?

Yes No How much: _____

FAMILY HISTORY:

Diseases that run in your family: _____

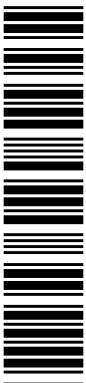
If YES please describe: _____

REFERRAL:

Who referred you to the office today? _____

Their address: _____

CLINICIAN USE ONLY: DR _____ HAS REVIEWED THE ABOVE INFORMATION WITH THE PATIENT DATE: _____



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