Patient ID: 

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.

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:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>
| ☐ | ☐ | Asthma/Lung disease
| ☐ | ☐ | Arthritis
| ☐ | ☐ | Diabetes
| ☐ | ☐ | Excessive bleeding
| ☐ | ☐ | Fevers
| ☐ | ☐ | Heart Disease

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>
| ☐ | ☐ | Heartburn/Reflux
| ☐ | ☐ | Kidney disease
| ☐ | ☐ | Migraines
| ☐ | ☐ | Seizures
| ☐ | ☐ | Depression
| ☐ | ☐ | Stroke

If YES please describe:________________________

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:______________