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Problem: State why you want to see the Practitioner.

Medications: List all medications you are taking.

Allergies: What medications or food are you allergic to?

Past Medical History: List any past illnesses or surgeries:

Do you smoke? Yes ___ No ___ If no, have you ever smoked in the past? Yes ___ No ___ Quit date: _____

Review of Symptoms: Circle any symptom below that describes a problem you are now having.

- Allergic: Itchy ears, Itchy eyes, Itchy nose, Hives (welts), Nasal drainage, Nasal congestion, Excessive sneezing
Eyes: Double vision, Blurred vision, Difficulty with vision
Ears: Ear infections, Pressure in ears, Difficulty hearing
Mouth: Itchy mouth, Mouth lesions, Teeth problems
Throat: Itchy throat, Throat clearing, Phlegm in throat
Sinus: Post Nasal Drip, Nasal blockage, Sinus pressure, Frequent colds, Sinus infections, Difficulty smelling, Sinus headaches
Respiratory: Coughing, Wheezing, Chest tightness, Chest congestion, Trouble breathing, Excessive sputum, Shortness of breath
Constitutional: Fever, Nausea, Weight Loss, Constipation, Trouble sleeping
Skin: Hives, Swelling, Skin rash, Skin lesion, Skin itching
Musculoskeletal: Fatigue, Dizziness, Weakness, Muscle pain, Muscle aches
Cardiovascular: Fainting, Chest Pain, Palpitations, Heart problems, High blood pressure
Gastrointestinal: Ulcers, Diarrhea, Vomiting, Heartburn, Stomach pain

Please describe any symptom(s) not listed above:

Have you had a bad reaction to an insect sting or bite? Yes ___ No ___ If yes, what insect? _____

Modifying factors: Circle any item below that makes you worse:

- Dust, Exertion, Raking leaves, Cleaning house, Smoke, Animals, Mowing the grass, Weather changes, Odors, Foods, Exercise, Change of season, Anger, Infection, Vacuuming, Air conditioning

Family History: Who in your family has had?

- Cancer _____
Heart attack _____
Allergies _____
Asthma _____
High blood pressure _____
Headaches _____
Other _____