Cleveland Head and Neck Clinic

Today's Date________________

Patient Name____ Date of Birth____________________________

Name of favorite pharmacy, address, and phone number____

I. History

1. Chief complaint (Why you are here today?) ____
____
____

2. History of the Illness:

a) Location/When did it start?____
____

b) Quality of the Problem (Sharp or Dull pain?)____

c) Severity (Mild, Moderate, or Severe) ____

d) Timing (During exercise, at night, gets worse in the spring, etc.) ____________________________
____

e) Context (Worsening, Recurrent) ____

f) What makes it better (Heat, Cold, Rest, Antihistamines, etc.) ________________________________
____

g) Associated Symptoms____

II. **Past History** Height _____________ Weight ______________

1. Illnesses: Check all that apply:

___Hypertension
___Diabetes Mellitus
___Heart Attack/Coronary Artery Disease
___High Cholesterol
___Arrhythmia
___COPD/Emphysema
___Asthma
___Tuberculosis
___GERD (Esophageal Reflux)
___Peptic Ulcers
___Hepatitis/Liver Disease
___Kidney Disease/Chronic Renal Failure
___Kidney Stones
___Gout
___Allergic Rhinitis
___Cancer
___Temporomandibular Joint Disorder(TMJ)
___Arthritis/ ?Rheumatoid
___Lupus
___Fibromyalgia
___Thyroid Disorder(nodules, hypo, hyper)
___Parathyroid Disease
___Multiple Sclerosis
___Parkinson's Disease
___Stroke
___Hearing Loss
___Glaucoma
___Anxiety/Depression
___Bleeding disorder
___Deep Vein Thrombosis
___HIV/AIDS

Please list any other medical conditions:____

2. Operations:

1.____Date:______________________
2.____Date:______________________
3.____Date:______________________
4.____Date:______________________
5.____Date:______________________

3.

Medication	**Dose**	**Taken for?**

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4. **Allergies to Medications? No Yes Please List** ____
____
5. **Allergic to Latex? No Yes** ____

6. **Please write which family members have had the following (or leave blank if none):**

Hypertension_______________________________
Heart Disease_______________________________
Diabetes___________________________________
Cancer____________________________________

Thyroid Disease___________________________________
Hearing Loss/Ear disease________________________
Bleeding Problems________________________________
Anesthesia Problems______________________________

7. **If female, are you pregnant? No Yes**

8. **Social History**
   a) Smoking No Yes How Much? ____
   b) Chewing Tobacco No Yes How Much? ____
   c) Alcohol Use No Yes How Much? ____
   d) Occupation:____

III. **Review of Systems: Check all that apply:**

GENERAL
___Fever/Chills
___Wt. Loss
___Wt. Gain
___Fatigue

HEENT
___Blurred/Double Vision
___Eye Pain
___Itchy, Watery Eyes
___Hearing Loss
___Dizziness
___Ear Noise/Tinnitus
___Ear Pain
___Stuffy Nose
___Runny Nose
___Sneezing
___Snoring
___Mouth Sores
___Sore Tongue
___Lump in the Throat
___Hoarseness
___Difficulty Swallowing
___Allergies/Hayfever

CARDIOVASCULAR
___Chest Pain
___Palpitations/Rapid Heart Rate
___Lightheadedness

PULMONARY
___Shortness of Breath
___Cough
___Wheezing
___Phlegm

GI
___Heartburn/Belching
___Gas
___Abdominal Pain
___Constipation
___Diarrhea
___Dark/Bloody Stool

SKIN
___Rash
___Itching
___Easy bruising/bleeding
___Edema

ENDOCRINE
___Thyroid Trouble/Goiter
___Heat or Cold Intolerance

MUSCULOSKELETAL
___Joint pain/swelling
___Jaw pain
___Neck pain
___Back pain
___Muscle Pain

NEUROLOGIC
___Headaches/Facial Pain
___Head Trauma
___Anxiety/Depression
___Tremors
___Numbness
___Weakness

GU
___Frequent urination
___Painful urination
___Urinary/Vaginal Bleeding

OTHER
___Blood transfusions
___HIV

Other complications: ____
____
____

For office use only:
Vital Signs: B/P: ___________ Pulse: __________Temp____________