Cleveland Nasal Sinus & Sleep Center

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Date: ______________________________________

CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit? ______________________________________
2. How long have you had this problem? ______________________________________
3. How severe is this problem? (Circle) 1 (Mild) 2 3 4 5 6 7 8 9 10 (very severe)
4. How often does this problem occur? ☐ constant ☐ comes and goes
5. What makes it better? ______________________________________
6. What makes it worse? ______________________________________
7. What other symptoms are you having? ______________________________________

PAST MEDICAL HISTORY (Please check any illnesses you have):

☐ High blood pressure	☐ Asthma/Emphysema	☐ Rheumatic fever	Others:
☐ Kidney disease	☐ Stroke, mini-stroke	☐ Sinusitis	______________
☐ Diabetes	☐ Heart disease/Angina	☐ Peptic ulcers	______________
☐ Neck/Back disease	☐ Hepatitis/Liver disease	☐ Thyroid disease	______________

☐ Cancer (please list type and date diagnosed): ______________________________________

PAST SURGICAL HISTORY (Please check any surgeries you have had):

☐ Heart bypass/valve	☐ Gall bladder	☐ Prostate removal	Others:
☐ Coronary angioplasty	☐ Lung surgery	☐ Colon removal	______________
☐ Carotid artery surgery	☐ Joint replacement	☐ Appendix removal	______________
☐ Vascular bypass	☐ Back surgery	☐ Sinus surgery	______________
☐ Mastectomy	☐ Brain surgery	☐ Tonsillectomy	______________
☐ Heart transplant	☐ Liver transplant	☐ Kidney transplant	______________

MEDICATIONS (List all your current medications and the dose you take):

Medication______________________________ Dose______________________

Medication______________________________ Dose ______________________

Medication______________________________ Dose ______________________

Medication______________________________ Dose ______________________

Do you take Aspirin or Ibuprofen? ☐ Yes ☐ No
Do you take Warfarin (Coumadin)? ☐ Yes ☐ No
Have you taken steroids within the past year? ☐ Yes ☐ No

ALLERGIES (List medications/foods you are allergic to and what happens when you take them):

Medication______________________________ Reaction______________________

Medication______________________________ Reaction______________________

Medication______________________________ Reaction______________________

FAMILY HISTORY (Check all illnesses that run in your family):

☐ Hearing loss	☐ Alcoholism	☐ Heart attack	Others:
☐ High blood pressure	☐ Psychiatric illness	☐ Cancer	______________
☐ Sickle cell anemia	☐ Bleeding problems	☐ Diabetes	______________
☐ Poor circulation	☐ Anesthesia reaction	☐ Stroke	______________
			______________

SOCIAL HISTORY:

Occupation_______________________________________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic partner
How many children do you have? ____
Have you ever smoked? ☐ Yes ☐ No (☐ cigarettes, ☐ cigar, ☐ pipe)
How much, and for how long have you smoked? _________ packs per day for __________ years. Quit? ☐ Yes ☐ No When?______________
How much alcohol do you drink each day? ____
List any street drugs you currently use: ____
Do you have any drug addictions? ☐ Yes ☐ No

REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past):

CONSTITUTIONAL

☐ Weight loss__________pounds in the past _____________ weeks ☐ Fever, chills

EYES:

☐ Double vision
☐ Loss of vision
☐ Eye pain

ENT:

☐ Hearing loss
☐ Ringing in ears
☐ Dizziness
☐ Ear pain
☐ Ear drainage
☐ Nose drainage
☐ Nasal congestion
☐ Facial pain
☐ Headaches
☐ Sore mouth/throat
☐ Swallowing pain
☐ Voice change
☐ Snoring
☐ Hoarseness
☐ Poor sleep

CARDIOVASCULAR/PULMONARY:

☐ Chest pain
☐ Poor circulation
☐ Shortness of breath
☐ Heart attack
☐ Leg pain during walking
☐ Asthma
☐ Irregular heartbeat
☐ Coughing up blood

GASTROINTESTINAL:

☐ Stomach ulcers
☐ Blood in stool
☐ Nausea/vomiting
☐ Trouble swallowing
☐ Diarrhea
☐ Abdominal pain

GENITOURINARY:

☐ Blood in urine ☐ Pain during urination ☐ Difficulty making urine

MUSCULOSKELETAL:

☐ Neck/Spine surgery ☐ Neck or Back disorder ☐ Arthritis

NEUROLOGICAL:

☐ Stroke
☐ Loss of sensation
☐ Ministroke
☐ Paralysis of an arm or leg
☐ Temporary loss of vision or speech control
☐ Facial paralysis

SKIN:

☐ Skin cancers ☐ Allergy to medical tape, iodine, or latex

PSYCHIARIC:

☐ Clinical depression
☐ Hallucinations
☐ Schizophrenia
☐ Other psychiatric disorder (list)____
☐ Anxiety

INFECTIOUS DISEASE:

☐ Hepatitis
☐ TB
☐ HIV/AIDS
☐ Mononucleosis

I have personally reviewed this history and review of systems:

____ ____

Physician Signature Date