



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 2 3 4 5 6 7 8 9 10
Mild 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):

- | | | | |
|--|--|--|---------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Rheumatic fever | Others: _____ |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke, mini-stroke | <input type="checkbox"/> Sinusitis | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease/Angina | <input type="checkbox"/> Peptic ulcers | _____ |
| <input type="checkbox"/> Neck/Back disease | <input type="checkbox"/> Hepatitis/Liver disease | <input type="checkbox"/> Thyroid disease | _____ |
| <input type="checkbox"/> Cancer (please list type and date diagnosed): _____ | | | |

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

- | | | | |
|---|--|--|---------------|
| <input type="checkbox"/> Heart bypass/valve | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Prostate removal | Others: _____ |
| <input type="checkbox"/> Coronary angioplasty | <input type="checkbox"/> Lung surgery | <input type="checkbox"/> Colon removal | _____ |
| <input type="checkbox"/> Carotid artery surgery | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Appendix removal | _____ |
| <input type="checkbox"/> Vascular bypass | <input type="checkbox"/> Back surgery | <input type="checkbox"/> Sinus surgery | _____ |
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Brain surgery | <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Heart transplant | <input type="checkbox"/> Liver transplant | <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you take Warfarin (Coumadin)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Have you taken steroids within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> 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):

- | | | | |
|--|--|---------------------------------------|---------------|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart attack | Others: _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Anesthesia reaction | <input type="checkbox"/> 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