

ESTABLISHED PATIENT HEALTH HISTORY

DATE _____ (STAFF REVIEW _____)

Last Name _____ First _____ MI _____ Date of Birth _____ Age _____

Has your insurance changed? ___yes ___no Has your address or personal information changed? ___yes ___no

Were you referred to our office? ___ yes ___no If yes, referring doctor: _____

Please describe the reason for visit _____

PLEASE TELL US ABOUT YOUR CURRENT PROBLEM & SYMPTOMS

Please fill out ONE of the following sections, feel free to ask our staff for assistance if you are unsure which section to complete.

A. If your appointment today is for a **NEW PROBLEM** (something we have not seen you for in the past) please complete this section, otherwise skip.

When did your problem/symptoms begin? _____ day(s) ago _____ week(s) ago _____ year(s) ago

Was there any precipitating event or circumstances that contributed or caused your problem?

Have you ever has this problem before? ___ yes ___ no Explain _____

How many times a year do you get sick? _____ 1-2 times _____ 3-4 times _____ 5-6 _____ 6+ per year.

My symptoms are experienced (pick one)

My symptoms are worse in the (circle one):

_____ Symptoms have recently become constant.

Winter | Spring | Summer | Fall | All Year

_____ Symptoms are experienced intermittently.

Other times symptoms are worse _____

_____ My symptoms have resolved.

Please rate your symptoms now? (circle one)

Mild | Moderate | Severe

What other medications have you taken **for this problem**?

(Please list all antibiotics, over the counter and prescription medications used for this problem.)

1. _____ 3. _____

2. _____ 4. _____

How did you respond to the medication(s) and/or treatment(s) you've taken for this problem?

_____ These medications did not help.

_____ These medications helped for a while but are no longer working.

_____ I only improved slightly with these medications.

_____ These medication helped.

Are you currently using any of the following: _____ Sinus Rinses, _____ Allergy Drops, _____ Allergy Shots

Do you have a history of: _____ Eczema/Asthma, _____ Environmental Allergies, _____ Reflux, _____ Migraine

B. If your appointment today is to **FOLLOW UP ON TREATMENT** for a current problem please complete.

Were you given any new medication(s) or treatment regimen at your last visit? ___ yes ___no

Medication name(s) or treatment _____

Did you take them as directed? ___yes ___no If not please explain _____

How did you respond to the medication(s) and/or treatment(s) you've taken for this problem?

_____ These medications did not help.

_____ These medications helped for a while but are no longer working.

_____ I only improved slightly with these medications.

_____ These medication helped.

What was your worst or most bothersome symptom before treatment? _____

Has this improved or changed in anyway? Such as (circle if applicable)

Less frequent More frequent Cant tell Unchanged

Less painful More painful Can't tell Unchanged

Occurs few times per day or week Same Unchanged

Explain: _____

Have you noticed any new symptoms that you feel are associated with this problem? ___ yes ___no

Describe _____

Have you ever been allergy tested? ___ yes ___ no When _____Where _____ Results (+) or (-)

Have you had a CT scan preformed in our office? ___ yes ___ no When? _____ (we may review these)

Have you ever had a laryngoscopy (an evaluation of your throat & vocal cords) ___yes ___no? When _____

If you've had surgery for this problem when was your surgery? _____

Are you currently on any of the following: ___ Prescribed Rinses, ___ Allergy Drops, ___ Allergy Shots

Do you have a history of: ___ Eczema/Asthma, ___ Environmental Allergies, ___Reflux, ___ Migraine

Please share any other information about this problem that may be helpful to your visit.

C. If you are here today to follow up AFTER SINUS SURGERY please complete this section otherwise skip.

This is my (circle one) 1st 2nd 3rd 4th post-operative visit.

Are you currently using Nasal Saline Irrigation? _____ How many times per day? _____

Are you currently using any other nasal sprays (circle) Nasal steroid Nasal anti-histamine

Do you have allergies? (respond yes only if you have recently been allergy tested) ___ yes ___ no?

Are you taking any other medications for allergies? List _____

Do you have a history of reflux? ___ yes no ___ Are you on reflux medication? ___ yes ___no

What was your worse symptom/problem before surgery? _____

Please tell us how you are doing _____