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**PATIENT HEALTH HISTORY**

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ SSN# \_\_\_\_\_  
 Address \_\_\_\_\_ Zip \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Telephone #'s Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
 Sex  Male  Female HT \_\_\_\_\_ WT \_\_\_\_\_ Pharmacy Preference (include location) \_\_\_\_\_  
 Name of referring physician \_\_\_\_\_ Name of Primary care physician \_\_\_\_\_  
 Parent's name if patient is under 18 yrs. \_\_\_\_\_

**REASON FOR VISIT TODAY** \_\_\_\_\_

**(TAB 1) PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY)**  
**(This includes prescriptions, topical, over-the-counter, herbal medications, blood thinners & vitamin supplements)**

Name of drug	Dosage	How often taken

**(TAB 2) Are you allergic to ANY medication?**  No  Yes **If yes, please list below.**

Name of Medication	Type of Reaction

**(TAB 3) NON -MEDICATION ALLERGIES**  
 Are you allergic to contrast dye? No  Yes   
 Are you allergic to any foods? No  Yes  **If yes, please describe** \_\_\_\_\_  
 Have you had any allergy testing in the past? Yes, skin tests  blood tests  No   
 Are you currently taking Allergy Shots? No  Yes  **If yes, do you find them helpful?**  No  Yes

**(TAB 4) PAST HEALTH HISTORY** Have you ever been *DIAGNOSED* with any major health problems? Indicate below:

Cancer (type) \_\_\_\_\_

**HEAD and FACE:**

Cluster headache  No  Yes  
 Migraine headache  No  Yes

**EYES:**

Cataracts  No  Yes  
 Glaucoma  No  Yes  
 Dry Eyes  No  Yes

**EARS:**

Chronic Ear Infections  No  Yes  
 Hearing loss from aging  No  Yes  
 Hearing loss from trauma  No  Yes  
 Meniere's Disease  No  Yes

**NOSE and SINUS:**

Chronic Sinusitis  No  Yes  
 Deviated Septum  No  Yes  
 Nasal Allergies  No  Yes  
 Recurrent Sinusitis  No  Yes

**MOUTH and THROAT:**

Chronic Tonsillitis  No  Yes  
 Recurrent Tonsillitis  No  Yes  
 Sleep Apnea  No  Yes

**HEART and BLOOD VESSELS**

Elevated Cholesterol  No  Yes  
 Heart Attack  No  Yes  
 Hypertension  No  Yes

**(TAB 4 cont'd)**

**LUNGS and RESPIRATORY:**

Asthma  No  Yes  
Chronic Bronchitis  No  Yes  
Emphysema  No  Yes

**STOMACH and DIGESTIVE:**

Reflux  No  Yes  
Gallbladder inflammation (cholecystitis)  No  Yes  
Stomach ulcer  No  Yes

**BRAIN and NERVOUS SYSTEM:**

Epilepsy  No  Yes  
Multiple Sclerosis  No  Yes  
Stroke  No  Yes

**GLANDS, HORMONES & SUGAR CONTROL:**

Diabetes (unsure of type)  No  Yes  
Diabetes (type I)  No  Yes  
Diabetes (type II)  No  Yes  
Graves Disease  No  Yes  
Hypothyroidism  No  Yes  
Hyperthyroidism  No  Yes

**BLOOD and LYMPH NODE:**

Anemia (unknown cause)  No  Yes  
Anemia (iron deficiency)  No  Yes

**ALLERGIES, IMMUNE or INFECTIOUS PROBLEMS:**

AIDS  No  Yes  
HIV  No  Yes  
Infectious Mononucleosis (Mono)  No  Yes

**DIAGNOSIS NOT LISTED** \_\_\_\_\_

**(TAB 5) SURGERIES AND HOSPITALIZATIONS**

Have you ever had any problems with anesthesia (being numbed or put to sleep)?  No  Yes

If yes, please list what sort of problems. \_\_\_\_\_

Have you been hospitalized for a non-surgical problem?  No  Yes

If yes, list hospitalizations, the reason for admission and the date. \_\_\_\_\_

Have you ever had surgery?  No  Yes

If yes, mark any of the following you have had:

Sinus surgery?  No  Yes dates \_\_\_\_\_ Tonsillectomy?  No  Yes date \_\_\_\_\_

Other types of surgeries? \_\_\_\_\_

**(TAB 6) SERIOUS INJURIES**

Have you ever had a serious injury such as face, head, neck, back, or other injury?  No  Yes

If yes, list and describe the type of injury and when it occurred. \_\_\_\_\_

**(TAB 8) FAMILY HISTORY**

No Family History of Significant or Pertinent Health Problems:

If you answer yes, please tell us which family member

Cancer (type) \_\_\_\_\_

Specific Anesthesia Problem:  No  Yes \_\_\_\_\_

**Head and Face:**

Migraine Headache  No  Yes \_\_\_\_\_

**Ears:**

Hearing Loss before age 20  No  Yes \_\_\_\_\_

Hearing Loss after age 20  No  Yes \_\_\_\_\_

**Nose and Sinus:**

Chronic Sinus Disease (had surgery)  No  Yes \_\_\_\_\_

Chronic Sinus Disease (no surgery)  No  Yes \_\_\_\_\_

**Heart and Blood Vessels:**

Heart Disease  No  Yes \_\_\_\_\_

High Blood Pressure  No  Yes \_\_\_\_\_

**Lungs & Respiratory:**

Asthma  No  Yes \_\_\_\_\_

**Brain and Nervous:**

Stroke  No  Yes \_\_\_\_\_

**Blood & Lymph Node Problems:**

Bleeding/clotting problems  No  Yes \_\_\_\_\_

**Glands, Hormones & Sugar Control:**

Diabetes  No  Yes \_\_\_\_\_

Age relative was diagnosed \_\_\_\_\_

**OTHER PERTINENT FAMILY HISTORY:**

\_\_\_\_\_  
\_\_\_\_\_

**(TAB 9) SOCIAL HISTORY**

What is or was your occupation? \_\_\_\_\_

Check here if you are retired.

Marital Status \_\_\_\_\_

Have you ever used tobacco in any form? .....  No  Yes

If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Have you ever used alcohol in any form? .....  No  Yes

If yes, please complete the following:

Type of Alcohol	From year	To year
Beers per week: _____		
Wine glasses per week: _____		
Other: (list type) _____		

Do you use drugs recreationally?  No  Yes If yes, please specify \_\_\_\_\_

Caffeine use:  None  About 1 drink/day  2-3 drinks/day  4 or more drinks/day  other \_\_\_\_\_

**(TAB 10) REVIEW OF SYSTEMS: CHECK any problems you have or have had recently in the following areas.**

**General health problems:**  No  Yes  
(fever, sleeping problems, unintentional weight loss)

**Eye Problems:**  No  Yes  
(blurred vision, double vision, loss of vision)

**Ear Problems:**  No  Yes  
(dizziness, drainage, hearing loss, infection, pain, ringing)

**Nose and Sinus:**  No  Yes  
(nasal congestion, itchy nose, nosebleeds, post-nasal drip, runny nose, sneezing)

**Mouth and Throat:**  No  Yes  
(hoarseness or other voice change, snoring, sore throat)

**Heart or Circulation:**  No  Yes  
(fainting, bluish color of lips or nails, chest pain, irregular heartbeat, leg cramps, swelling ankles)

**Lung or Respiratory:**  No  Yes  
(non-productive cough, productive cough, shortness of breath, wheezing)

**Stomach problems:**  No  Yes  
(abdominal pain, diarrhea, heartburn, nausea, vomiting)

**Bones, Joints and Muscles:**  No  Yes  
(pain in back, painful joints, stiffness in joints, swelling joints)

**Brain or Nervous System:**  No  Yes  
(change in alertness, headache, loss of consciousness, numbness, facial pain, seizures, weakness)

**Problems with Glands, Hormones:**  No  Yes  
(feel cold, feel hot when others are not, increased appetite, fatigue, neck has enlarged, unwanted weight change)

**Problems with Blood or Lymph nodes:**  No  Yes  
(bleeds excessively after injury, bruises easily, mass in neck)

**Problems with Allergies:**  No  Yes  
(food intolerances, hives, severe reaction to insect bites)

**PROBLEM NOT LISTED:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Authorization**  
(please sign below)

I hereby authorize Richard A. Levin, MD, DMD or Lawrence J. Fliegelman, MD to furnish information to my insurance carries concerning my injuries and treatment.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

