Rhinology Information Form - Dr. Bolger

NORTH FLORIDA SINUS CENTER

Please fill out this form to help us understand your medical history so we can better care for you.

Primary Care Doctor:'s Name: _____
Address: _____
FAX: _____

Patient's Name: _____
Reason for visit: _____

What are the main symptoms you are experiencing? _____
_____

Have you ever had any of the following medical problems? (circle if yes)
high blood pressure *heart disease* *asthma/COPD* *stroke* *depression* *sleep apnea*
acid reflux *diabetes* *HIV/AIDS* *cancer* *hepatitis*
Other: _____
Please list surgeries:

_____ _____ _____
_____ _____ _____
Medications:

_____
_____
Allergic reaction to medications: _____
Adverse reaction to medication: _____
Family history of major medical problems:
cancer *diabetes* *heart disease* *d) other* _____
Occupation: _____
Have you ever smoked? *yes / no* If yes, ___ packs per day for ___years. When quit?
Do you drink alcohol? *yes/ no* approximately ___ drinks per week
ROS: Please circle if you suffer from the following symptoms or problems:

constitutional:	*fatigue, weakness, weight loss, fever*
eyes:	*excess tearing, change in vision, other*
ears:	*hearing loss, imbalance, ringing in the ears*
nose:	*nasal congestion, nose bleeds, loss of smell, other*
cardiovascular:	*chest pain, palpitations, murmur, heart attack, othe:*
respiratory:	*short of breath, cough, wheezing, previous TB, bronchitis*
gastrointestinal:	*difficulty swallowing, nausea/vomit, other*
urinary:	*flank pain, pain on urination, abnormal urine*
musculoskeletal:	*joint pain, arthritis*
skin:	*skin conditions*
neurologic:	*headache, seizures, stroke, memory loss*
psychiatric:	*depression, OCD, bipolar disorder, ADD*
endocrine:	*diabetes, thyroid condition*
hematologic:	*bleeding problems with surgery*
allergy:	Have you every had allergy skin testing? *yes / no*
	If "yes" what allergies were detected? _____
	Have you had Allergy Shots (Immunotherapy)? *yes / no*
	If "yes" did it help? *yes / no*