

### Rhinology Information Form - Dr. Bolger

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

Patient's Name: \_\_\_\_\_ Age \_\_\_\_\_

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*

Primary Care Doctor's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 FAX: \_\_\_\_\_

Pharmacy \_\_\_\_\_, phone number \_\_\_\_\_