NORTH FLORIDA SINUS CENTER

Office: 904-595-7475 Fax: 904-595-7480

NAME: _____ DATE OF BIRTH: _____ AGE: _____ GENDER: _____

BEST TELEPHONE NUMBER TO REACH YOU: (_____) - _____ - _____ CELL PHONE: (_____) _____ - _____

MAILING ADDRESS: _____

MAY WE SEND TEXT MESSAGE APPOINTMENT REMINDERS? YES / NO _____ EMAIL: _____

NAME OF PHARMACY _____ LOCATION/PHONE# _____

EMERGENCY CONTACT NAME: _____ Phone: _____

PLEASE TELL US WITH WHOM WE CAN SHARE YOUR PROTECTED HEALTH INFORMATION: _____

PRIMARY CARE/FAMILY PHYSICIAN: _____

MAIN REASON FOR TODAY'S VISIT: _____

PAST MEDICAL HISTORY:

PLEASE CHECK ANY OF THE FOLLOWING CONDITION(S) WHICH AFFECT YOU CURRENTLY OR IN THE PAST:

Headaches		Heart Attack		Hearing loss	
Migraine		Coronary Artery Disease		Ear infections	
Dizziness		Ear ringing/head noise		Occupational noise exposure	
Diabetes Mellitus		High Blood Pressure		Increased Cholesterol/Lipids	
Asthma		Stroke		Depression	
COPD/Emphysema		Sinus Disease/Infections		Bleeding disorder	
Tuberculosis		Hepatitis B or C		History of cancer – type:	
Thyroid Disease		Skin Disorders (cancer, rashes)		Other (please write below):	
Liver Disease		Gout			
HIV		Rheumatoid Arthritis			
GERD/Reflux		Osteoarthritis			

PAST SURGICAL HISTORY:

PLEASE LIST ANY PRIOR SURGERIES BELOW:

	Surgery	Year		Surgery	Year
1.			4.		
2.			5.		
3.			6.		

ALLERGIES:

PLEASE LIST ANY ALLERGIES TO **MEDICATIONS**, **FOOD** or **ENVIORNMENT**:

ARE YOUR IMMUNIZATIONS UP TO DATE: Y / N

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MEDICATIONS:

NAME	Strength (Milligrams)	Dose/times taken per day	Office Use

SOCIAL HISTORY:

Race/Ethnicity (not required): _____ Marital Status: _____ Live Alone? _____ YES__ NO___

Number of children: _____ Occupation: _____ Retired? _____ (Yes/No)

DO YOU CURRENTLY SMOKE CIGARETTES? _____ #_____ of packs per day for #_____ years DO YOU USE CHEWING TOBACCO OR SNUFF? _____ Yes/No DO YOU VAPE, HOOKAH, OR USE ANY OTHER TYPOE OF NICOTINE? _____	Previous Smoker? Quit When: _____
Drink Alcohol? _____ If YES, _____ # of drinks per Day / Week # _____ of years	
Past Alcohol Abuse: Yes No #_____ of Years of Alcohol Abuse	Quit when: _____

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FAMILY HISTORY: (PLEASE CHECK ALL THAT APPLY)

Headaches		Heart Attack		Ear infections	
Migraine		Coronary Artery Disease		Hearing loss	
Diabetes Mellitus		High Blood Pressure		High Cholesterol	
Asthma		Stroke		Depression	
COPD/Emphysema		Sinus Disease/Infections		Bleeding disorder	
Tuberculosis		Hepatitis		History of cancer - type:	
Thyroid Disease		Skin Disorders (cancer, rashes)			
Liver Disease		Gout		Other (please write below):	
HIV Positive		Rheumatoid Arthritis			
GERD/Reflux		Osteoarthritis			

REVIEW OF SYSTEMS: (PLEASE CHECK ALL THAT APPLY)

Weight change		Nosebleeds		Sinus Tenderness	
Fever		Nasal congestion		Sinus infections	
Chills		Post-nasal drip		Dry Mouth	
Sweating		Heart palpitations		Sore Throat	
Loss of appetite		Cough		Difficulty Swallowing	
Night sweats		Swelling legs/ankles		Pain with Swallowing	
Vision changes		Passing/blacking out		Lump in throat	
Double vision		Wheezing		Decreased smell	
Ear pain		Shortness of Breath		Cough	
Decreased hearing		Loss /change of appetite		Headache	
Ears popping		Nausea/Vomiting		Facial pain/pressure	
Hoarseness		Heartburn		Headaches	
Drainage from ears		Regurgitation of food		Loss of consciousness	
Ringing in ears		Acid Reflux		Dizziness	
TMJ/jaw pain		Thyroid problems		Itchy eyes	
Clench/Grind teeth		Thyroid goiter		Watery eyes	
Abnormal taste in mouth		Light-headedness		Itchy nose	
Burning mouth		Easily bruising		Itchy ears	
Burning tongue		Bleeding disorder		Sneezing	
Rashes		Lymph node swelling			

For Office Use Only

Date Reviewed: _____ Reviewed by: _____DR_____MA

Date Reviewed: _____ *Reviewed by:* _____*DR*_____*MA*