NORTH FLORIDA SINUS CENTER

Iman Naseri, M.D., F.A.C.S.

6817 Southpoint Parkway, Suite 502
Jacksonville, FL 32216
Phone: (904) 595-7475
Fax: (904) 595-7480

Name: _____ Date of birth: _____ Age: _____

Best telephone number to reach you: ( ) - _____- _____ (landline/mobile)

Preferred method of contact for future appointments/reminders: text/ call/ e-mail (please circle one)

E-mail: _____ Primary care/family physician: _____

Emergency contact: _____ Phone: _____

Pharmacy name: _____ Telephone# (optional): _____

Reason for today's visit: _____

PAST MEDICAL HISTORY:

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

Migraine headaches		Heart Attack/Stent/Angina		Hearing loss/Ears ringing (tinnitus)	
Dizziness/Vertigo		Obstructive sleep apnea		Chronic ear infections/Ear drainage	
Diabetes Mellitus		High Blood Pressure		Depression/anxiety disorder	
Asthma/COPD/Emphysema		Stroke		Bleeding disorder/Current anticoagulant use	
Prior skin cancer		Chronic Sinus Disease/Infections		History of cancer – type:	
Tuberculosis/ Hepatitis B or C/ HIV		IgA or IgM immunodeficiency		Other (please write below):	
Hyper or hypo-thyroidism		Autoimmune disorder (Lupus)			
GERD/Reflux		Rheumatoid Arthritis			

PAST SURGICAL HISTORY (LIST ANY PRIOR SURGERIES):

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

ALLERGIES (LIST ANY ALLERGIES TO MEDICATIONS OR FOOD):

ARE YOUR IMMUNIZATIONS UP TO DATE: Y / N

SOCIAL HISTORY:

DO YOU CURRENTLY SMOKE CIGARETTES OR CIGARS DAILY? YES / NO NUMBER DAILY OR PACKS PER WEEK: _____ HOW LONG HAVE YOU BEEN SMOKING (APPROXIMATE YEARS): _____	
CURRENTLY DRINK ALCOHOL DAILY? YES/NO IF YES, NUMBER OF DRINKS PER WEEK: _____ NUMBER OF YEARS: _____	
PREVIOUS ST ALCOHOL USE: YES/NO QUIT WHEN: _____	
CIRCLE ONE: RETIRED / CURRENTLY EMPLOYED	CIRCLE ONE: MARRIED SINGLE WIDOWED

MEDICATIONS:

Name	Strength (Milligrams)	Dose (Times per day)	*For office use*
May use back of this page for additional items			

FAMILY HISTORY: (PLEASE CHECK ALL THAT APPLY)

Cystic fibrosis		Stroke/ Heart Attack		Autoimmune disorder	
Migraine headaches		Rheumatoid Arthritis		Cancer - type:	
Diabetes Mellitus		Bleeding disorder			
Asthma		COPD/Emphysema			

REVIEW OF SYSTEMS: (PLEASE CIRCLE ALL THAT APPLY)

General: Fatigue - Fever - Night sweats – Unintentional weight loss

Eye: Double vision - Itchy eyes- Increased tearing

Ear: Drainage–hearing loss––dizziness–itchiness–ringing/noise

Nose & sinus: Congested–facial pressure pain–mouth breathing–nosebleeds–sneezing–runny nose

Mouth and throat: Difficulty swallowing- frequent throat clearing – snoring – hoarseness– mouth sores

Heart or circulation: Heart murmur–chest pain–swelling of ankles–palpitations

Lung or respiratory: Chronic cough–shortness of breath–wheezing

Stomach: Abdominal pain–constipation–diarrhea–heartburn–nausea–vomiting

I authorize my physician (NFSinus/ENTAAF) to photograph me for medical and/or surgery-related documentation purposes.

YES___ NO___ Initial Here: _____ Date: _____

For Office Use Only:

Date Reviewed: _____ Reviewed by: _____DR_____MA

Initials: _____

Today's Date: _____