THE SINUS INSTITUTE OF RHODE ISLAND
A division of ENT & Allergy, Inc.

NAME _____

DATE OF BIRTH _____

DATE OF VISIT _____

CHIEF COMPLAINT · *The main reason(s) for your visit* _____

HISTORY OF PRESENT ILLNESS · *Describe the location, duration, severity, and timing of your main problem*:

_____
_____
_____

List any associated symptoms: _____
What makes your problem(s) better? _____
What makes your problem(s) worse? _____

Prior medical treatment (medications/procedures) for your **current problem**:

_____
_____
_____

MEDICAL HISTORY · Please check all that apply to you:

[ ] High cholesterol
[ ] High blood pressure
[ ] Diabetes
[ ] Heart disease
[ ] Stroke or TIA ("mini-stroke")
[ ] Asthma
[ ] COPD (bronchitis/emphysema)
[ ] Obstructive sleep apnea (OSA)
[ ] Kidney disease
[ ] Thyroid disease
[ ] Liver disease/hepatitis
[ ] GERD ("acid reflux")
[ ] Anemia
[ ] Bleeding disorder
[ ] HIV or AIDS
[ ] Immunodeficiency
[ ] Eye disease (glaucoma, etc.)
[ ] Skin disease (eczema, etc.)
[ ] Psychiatric disorder(s)
[ ] Cancer: _____
[ ] Autoimmune disease: _____
[ ] Tumor/growth/cyst: _____
[ ] Other: _____
_____
[ ] Head injury
[ ] Facial trauma/fractures
[ ] Tuberculosis

SURGICAL HISTORY · *Please list ALL surgeries (including plastic surgery, tonsillectomy, etc.)*:

Year	*Procedure*	*Year*	*Procedure*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Do you **smoke (tobacco)** currently? [ ] Yes [ ] No
If yes, how many **packs per day**? _____
For how many years have you smoked? _____

Have you **ever smoked**? [ ] Yes [ ] No
If yes, when did you quit smoking? _____

Do you use **e-cigarettes**? [ ] Yes [ ] No
Do you use **chewing tobacco**? [ ] Yes [ ] No

Do you drink **alcohol** currently**?** [ ] Yes [ ] No
If yes, how many **drinks per week**? _____

Have you ever used "**recreational drugs**"? [ ] Yes [ ] No
If yes, please list: _____

What is your **occupation**? _____

FAMILY MEDICAL HISTORY | *Please check all that apply to your **blood relatives***:

[ ] Cancer
[ ] Heart disease
[ ] Stroke
[ ] Asthma
[ ] Allergies
[ ] Diabetes
[ ] High blood pressure
[ ] Problem with general anesthesia
[ ] Bleeding disorders (e.g., hemophilia)
[ ] Autoimmune disease

ALLERGIES TO MEDICATIONS

[ ] No allergies
[ ] I am allergic to: _____

MEDICATIONS & SUPPLEMENTS

Do you take **blood thinners** (e.g., aspirin, warfarin/Coumadin, Plavix, etc.)? [ ] Yes [ ] No

Please list all current prescription and over-the-counter medications/supplements:

_____
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS | *Please check all that apply to you*:

Constitutional
[ ] Fever
[ ] Weight loss
[ ] Fatigue

Eyes
[ ] Dry eyes
[ ] Poor vision
[ ] Double vision

Cardiovascular
[ ] Chest pain
[ ] Palpitations

ENT
[ ] Dry mouth
[ ] Nose bleeds
[ ] Sneezing / "hay fever"

Respiratory
[ ] Cough
[ ] Shortness of breath
[ ] Wheezing/noisy breathing

Endocrine
[ ] Recent unplanned weight **loss**
[ ] Recent unplanned weight **gain**
[ ] Hormone therapy

Neurological
[ ] Tremors or hand shaking
[ ] Blackout spells
[ ] Seizures

Psychiatric
[ ] Anxiety
[ ] Depression
[ ] Panic attacks

Skin
[ ] Eczema
[ ] Psoriasis
[ ] Rashes or other skin lesions

Hematologic
[ ] Easy bruising/bruising

Genitourinary
[ ] Recurrent urinary infection
[ ] Blood in urine

GI
[ ] Heartburn
[ ] Chronic constipation
[ ] Frequent diarrhea

Other: _____
_____