

| H                          | PI SHEET   |            |            |            |            |              |         |          |            |          |                     |
|----------------------------|--|------------|------------|------------|------------|--------------|---------|----------|------------|----------|---------------------|
| Na                         | me   |            |            |            | B          | irth Date    | !       |          |            | Date     |                     |
| Ch                         | ief complaint or illness:                            |            |            |            |            |              |         |          |            |          |                     |
| 1.                         | What is the reason for today's                       | visit?     |            |            |            |              |         |          |            |          |                     |
| 2.                         | How long have you had this pr                        | oblem? _   |            |            |            |              |         |          |            |          |                     |
| 3.                         | How severe is this problem?                          | □ 1        | <b>□</b> 2 | □ 3        | □ 4        | <b>□</b> 5 [ | □ 6     | □ 7      | □8         | □9       | □ 10                |
|                            |  | MILD       |            |            |            |              |         |          |            | VERY     | / SEVERE            |
| 4.                         | Have you had your hearing tes                        | ted in the | e last yea | ar? □ Ye:  | s □ No Isi | t ever dif   | fficult | to under | rstand sp  | eech? [  | □ Yes □ No          |
| 5.                         | Have you had more than one s                         | inus infe  | ction in t | the last y | ear? 🗆 Yes | □ No D       | o you   | ever exp | perience   | sinus pr | ressure? ☐ Yes ☐ No |
| 6.                         | Do you have any hoarseness o                         | r change:  | s in your  | voice?     | ⊐ Yes □ No | Do you l     | have s  | soreness | or difficu | ılty swa | llowing? ☐ Yes ☐ No |
| 7.                         | Do you suffer from allergies su<br>If yes, describe: |            | •          |            |            |              |         | -        | ? (check   | appropr  | iate items)         |
| На                         | ve <b>you</b> or a <b>family member</b> eve          | r had the  | followin   | ng?        |            |              |         |          |            |          |                     |
|                            | ·  |            |            | •          | Brother(s) | Sister(s     | s)      |          |            |          |                     |
| Anesthesia Reactions       |  |            |            |            |            |              |         |          |            |          |                     |
|                            | ood Clots – DVT/PE                                   |            |            |            |            |              |         |          |            |          |                     |
| Bleeding Tendency Diabetes |  |            |            |            |            |              |         |          |            |          |                     |
|                            | e any of your family members <b>de</b>               | _          |            | _          | _          | _            |         |          |            |          |                     |
|                            | ou answered yes, which family n                      |            |            |            | ☐ Mother □ | l Father     | ☐ Bro   | ther(s)  | ☐ Sister(s | 5)       |                     |
| Ple                        | ease list any other chronic illnesso                 | es or dise | ases you   | ı have:    |            |              |         |          |            |          |                     |
| Lis                        | t all previous surgeries                             |            |            |            |            | Montl        | h/Year  | r        |            |          | ☐ See Attached List |
| _                          |  |            |            |            |            | _            |         |          |            |          | -<br>-              |
|                            | ug allergies   |            |            |            |            |              |         |          |            |          | -                   |
| 1.                         |  |            |            |            |            |              |         |          |            |          |                     |
| <ol> <li>3.</li> </ol>     |  |            |            |            |            |              |         |          |            |          |                     |
|                            | edications (List all current medica                  |            |            |            |            |              |         |          |            |          | ☐ See Attached List |
| 1.                         |  |            | •          | ou take, i |            |              |         |          |            | Dose     | 2                   |
| 2.                         |  |            |            |            |            |              |         |          |            |          | <u> </u>            |
| 3.                         |  |            |            |            |            |              |         |          |            |          | 2                   |
| 4.                         |  |            |            |            |            |              |         |          |            |          | 2                   |
| 5.                         |  | Dose       | !          |            |            |              |         |          |            |          | 2                   |

| Social history  |   |   |                             |  |  |  |  |  |  |  |  |
|---|---|---|-----------------------------|--|--|--|--|--|--|--|--|
| Occupation  | Marital                                 | Status: ☐ Married ☐ Sind  | gle □ Divorced □ Widowed    |  |  |  |  |  |  |  |  |
| •   |   | nild, do you live at home with □ Both Parents □ Mother □ Father |                             |  |  |  |  |  |  |  |  |
| Do you smoke or use tobacco? ☐ YES ☐ NO (☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Vapor)            |   |   |                             |  |  |  |  |  |  |  |  |
| If yes, How much? (Packs per day) for years.  |   |   |                             |  |  |  |  |  |  |  |  |
| Did you quit smoking? ☐ YES ☐ NO If yes, when?  |   |   |                             |  |  |  |  |  |  |  |  |
| Do you use alcohol?   YES  NO How much and how frequently?  |   |   |                             |  |  |  |  |  |  |  |  |
| List any street drugs you have used:  |   |   |                             |  |  |  |  |  |  |  |  |
| Do you have any drug or alcohol addictions? ☐ YES ☐ NO  |   |   |                             |  |  |  |  |  |  |  |  |
| Do you have any reason to believe you are at risk for HIV, AIDS, or HEPATITIS?                              |   |   |                             |  |  |  |  |  |  |  |  |
| REVIEW OF SYSTEMS:  |   |   |                             |  |  |  |  |  |  |  |  |
| (Please check any of the following that you are <b>CURRENTLY EXPERIENCING</b> or <b>BEING TREATED FOR</b> ) |   |   |                             |  |  |  |  |  |  |  |  |
| Constitutional  ☐ Recent weight change ☐ Fever/chills ☐ Fatigue   |   |   |                             |  |  |  |  |  |  |  |  |
| Eyes:   | ENT:                                    |   |                             |  |  |  |  |  |  |  |  |
| ☐ Double vision   | ☐ Hearing loss                          | ☐ Nose drainage   | ☐ Swallowing pain           |  |  |  |  |  |  |  |  |
| Loss of vision  | ☐ Ringing in ears                       | ☐ Nasal congestion  | ☐ Voice change              |  |  |  |  |  |  |  |  |
| ☐ Eye pain  | ☐ Dizziness                             | ☐ Facial pain   | ☐ Snoring                   |  |  |  |  |  |  |  |  |
| ☐ Eye disease or injury   | ☐ Ear pain                              | ☐ Headaches   | ☐ Hoarseness                |  |  |  |  |  |  |  |  |
| ☐ Wear contacts or glasses  | ☐ Ear drainage                          | ☐ Sore mouth/throat   | ☐ Poor sleep                |  |  |  |  |  |  |  |  |
| Cardiovascular/Pulmonary  | □ Haant attack                          |   |                             |  |  |  |  |  |  |  |  |
| ☐ Chest pain☐ Poor circulation☐   | ☐ Heart attack☐ Leg pain during walking | ☐ Irregular heartbeat☐ Coughing up blood                        | ☐ Feeling faint/lightheaded |  |  |  |  |  |  |  |  |
| ☐ Shortness of breath   | ☐ Wheezing                              | ☐ Unusual shortness of breath while climbing stairs             |                             |  |  |  |  |  |  |  |  |
| Gastrointestinal  | g                                       |   |                             |  |  |  |  |  |  |  |  |
| ☐ Stomach ulcers  | ☐ Nausea/vomiting                       | ☐ Diarrhea  | ☐ Constipation              |  |  |  |  |  |  |  |  |
| ☐ Blood in stool  | ☐ Trouble swallowing                    | ☐ Abdominal pain  |                             |  |  |  |  |  |  |  |  |
| Genitourinary   | -                                       |   |                             |  |  |  |  |  |  |  |  |
| ☐ Blood in urine  | ☐ Pain during urination                 | ☐ Difficulty making urine                                       | ☐ Kidney stones             |  |  |  |  |  |  |  |  |
| Musculoskeletal   |   |   |                             |  |  |  |  |  |  |  |  |
| ☐ Neck/spine injury   | ☐ Neck or back disorder                 | ☐ Arthritis   |                             |  |  |  |  |  |  |  |  |
| Neurological  |   |   |                             |  |  |  |  |  |  |  |  |
| ☐ Stroke  | ☐ Mini stroke (TIA)                     | ☐ Temporary loss of vision or speech control                    |                             |  |  |  |  |  |  |  |  |
| ☐ Loss of sensation   | ☐ Paralysis of an arm or leg            | ☐ Facial paralysis  |                             |  |  |  |  |  |  |  |  |
| Skin  |   |   |                             |  |  |  |  |  |  |  |  |
| ☐ Skin cancers  | ☐ Dermatitis/eczema                     |   |                             |  |  |  |  |  |  |  |  |
| Psychiatric   |   |   |                             |  |  |  |  |  |  |  |  |
| ☐ Clinical depression   | ☐ Anxiety                               | cy □ Schizophrenia psychiatric disorder (list)                  |                             |  |  |  |  |  |  |  |  |
| ☐ Hallucinations  |   |   |                             |  |  |  |  |  |  |  |  |
| Infectious Disease  | _                                       | _   | _                           |  |  |  |  |  |  |  |  |
| ☐ Hepatitis   | ☐ HIV/AIDS                              | ☐ Mononucleosis   | □TB                         |  |  |  |  |  |  |  |  |
| ☐ Herpes  | ☐ Syphilis                              | ☐ Gonorrhea   | ☐ Chlamydia                 |  |  |  |  |  |  |  |  |
| Have you ever had the follow  | _                                       |   |                             |  |  |  |  |  |  |  |  |
| ☐ Measles   | ☐ Mumps                                 | ☐ Chicken pox   |                             |  |  |  |  |  |  |  |  |