Name____D.O.B._______________Date_____________

FOR FEMALES: Is there a possibility you are pregnant? Yes___ No___ Date of last period:____________

Chief Complaint____

____

WITHIN THE LAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS:

☐ Frequent Headaches

☐ Severe Headaches

☐ Dizziness

☐ Blurred Vision

☐ Spots before Eyes

☐ Infected eyes

☐ Earaches

☐ Ear discharge

☐ Ringing in Ears

☐ Decreased Hearing

☐ Recurrent nose bleeds

☐ Nasal Congestion/Sinus pressure

☐ Recurrent Sinus Infection

☐ Nasal odors/Loss of smell

☐ Strange taste/Loss of taste

☐ Heartburn/Belching

☐ Hoarseness

☐ Persistent Difficulty Swallowing

☐ Enlarged glands

☐ Sore Throats

☐ Chronic Cough

☐ Coughing while lying down

☐ Coughing up blood

☐ Waking up short of breath

Patient Signature:____

Date:___________________________