

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_/\_\_\_/\_\_\_ **Medical Record** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the reason for your visit today**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you Seen Dr. Valet before?** (Pleasecircle one) **YES, Years ago**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NO**

**Primary care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Self-Referred**

(Space for Dr. Valet)

**Past Surgeries:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any problems with any of the following?**

* Nasal congestion
* Throat clearing
* Runny nose
* Hoarseness
* Itchy /watery eyes
* Loss of sense of smell
* Facial pressure/pain
* Itching (skin)
* Headaches
* Swelling (skin)
* Sinus infections
* Eczema
* Sneezing
* Coughing
* Post-nasal drainage
* Shortness of breath
* Wheezing

**Allergy**: (Please circle YES or NO)

Do you have allergies or hay fever? YES NO

Have you ever been tested for allergies? YES NO

What type of testing? Skin Blood (RAST) YES NO

Did you get allergy shots? YES NO

* + For how long? \_\_\_\_\_\_\_\_
  + Were they helpful? YES NO

Do you have any history of allergies to the following? **Circle**: Foods Latex Insect stings

**Sinus:** (Please circle YES or NO)

Do you have a history of sinus problems? YES NO

How many times have you been treated for a sinus infection with antibiotics in the last year? \_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an x-ray or CT scan of your sinuses? YES NO If yes, when and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had sinus surgery? YES NO If yes, when and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did surgery help? YES NO

**Asthma**: (Please circle YES or NO)

Have you ever been diagnosed with asthma? YES NO

Have you ever been to the emergency room because of your asthma? YES NO How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had to stay overnight in the hospital for your asthma? YES NO How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Medical History:**

**Do you have or have ever had any of the following conditions?** (Please check the following YES or NO)

YES NO YES NO YES NO

Thyroid condition \_\_\_\_ \_\_\_\_

Liver condition \_\_\_\_ \_\_\_\_

Diabetes/blood sugar problems \_\_\_\_ \_\_\_\_

Stomach ulcer \_\_\_\_ \_\_\_\_

Pneumonia \_\_\_\_ \_\_\_\_

Acid reflux \_\_\_\_ \_\_\_\_

Stroke/”mini strokes” \_\_\_\_ \_\_\_\_

COPD/emphysema \_\_\_\_ \_\_\_\_

Cancer \_\_\_\_ \_\_\_\_

Other lung condition \_\_\_\_ \_\_\_\_

Sleep apnea \_\_\_\_ \_\_\_\_

CPAP machine \_\_\_\_ \_\_\_\_

Cataracts \_\_\_\_ \_\_\_\_

Heart arrhythmia/palpitations \_\_\_\_ \_\_\_\_

Glaucoma \_\_\_\_ \_\_\_\_

Heart failure \_\_\_\_ \_\_\_\_

Heart stents/bypass \_\_\_\_ \_\_\_\_

High blood pressure \_\_\_\_ \_\_\_\_

Osteoporosis \_\_\_\_ \_\_\_\_

Depression/sadness \_\_\_\_ \_\_\_\_

HIV/AIDS \_\_\_\_ \_\_\_\_

Panic attacks/anxiety \_\_\_\_ \_\_\_\_

Kidney disease \_\_\_\_ \_\_\_\_

Other psychiatric conditions \_\_\_\_ \_\_\_\_

Alcoholism/drug dependency \_\_\_\_ \_\_\_\_

**Home medications: please list dose and frequency:**

**1. 8.**

**2. 9.**

**3. 10.**

**4. 11.**

**5. 12.**

**6. 13.**

**7. 14.**

**Medication Allergies:**

**Drug: Reaction: Drug: Reaction:**

**1. 8.**

**2. 9.**

**3. 10.**

**4. 11.**

**5. 12.**

**6. 13.**

**7. 14.**

**REVIEW OF SYMPTOMS**: Please check if you have had any of the following IN THE LAST 30 DAYS:

* Fever
* Fatigue
* Weight change
* Problems with vision
* Indigestion/Reflux
* Constipation
* Diarrhea
* Trouble swallowing
* Sleep problems/snoring
* Skin rashes/hives
* Urinary abnormalities
* Swollen glands
* Muscle pain, aches or cramps
* Chest pain
* Joint pain
* Depression – feeling blue
* Swollen ankles
* Anxiety – feeling nervous
* Dizziness

**Environmental History**:

Do you have any pets in the home? Yes No Cats Dogs Other / Inside Outside Both

Do pets sleep in your bedroom? Yes No

Has there been any water leakage or water damage in your home? Yes No If yes, has this been repaired? Yes No

What type of flooring? Carpet Hardwood Tile Vinyl Other

**Social History**:

Occupation:

Do you use any tobacco products

Have you ever smoked

Do you drink alcohol

Do you live alone? Yes/no Children at home? Yes /no

Married/Single/Divorced/Widowed/Partnership

**Family History:**

**Parent Sibling Child Grandparent**

**Mother/Father Male/Female Male/Female Maternal/Paternal**

Asthma \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

Sinus disease \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

Hay fever/allergies \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

Cystic fibrosis \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

Emphysema \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_