Sinus Solutions AT IMMUNOe

SMOKY HILL
15470 E SMOKY HILL RD, AURORA, CO 80015
P: 303.224.4711 | F: 720.870.2517

CHERRY CREEK
3150 E 3rd AVE #300, DENVER, CO 80206
P: 303.224.4711 | F: 720.870.2517

Patient History Questionnaire

Patient Name:_____DOB:_____Date:_____

Please complete this form to the best of your ability. This will allow our office to treat you appropriately and take into consideration your overall health history. Over time, your medical history may change, and you may be asked to update this form on a regular basis to help us to continue to provide the best medical care possible.

Reason for visit today: _____

Referring Physician: _____ Primary Care Physician: _____

Preferred Pharmacy: _____

Past Medical History:

- ☐ Allergies
- ☐ Asthma
- ☐ Anxiety
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Recurring Bronchitis
- ☐ Depression
- ☐ Diabetes
- ☐ Headache / Migraine
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Immune Dysfunction
- ☐ Kidney Disorder
- ☐ Recurring Pneumonia
- ☐ Reflux / GERD
- ☐ Seizure Disorder
- ☐ Sinus Infections
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Dysfunction
- ☐ Other: _____

Surgical History:

- ☐ Sinus Surgery Date:_____
- ☐ Septoplasty Date:_____
- ☐ Tonsillectomy Date:_____
- ☐ Adenoidectomy Date:_____
- ☐ Tymp & Tubes Date:_____
- ☐ Mastoidectomy Date:_____
- ☐ Fundoplication Date:_____
- ☐ Thyroid Surgery Date:_____
- ☐ Hernia Repair Date:_____
- ☐ Hip Surgery Date:_____
- ☐ Turbinate Reduction Date:_____
- ☐ Esophageal Dilation Date:_____
- ☐ Appendectomy Date:_____
- ☐ Colonoscopy Date:_____
- ☐ Eye Surgery Date:_____
- ☐ Gallbladder Date:_____
- ☐ Hand / Wrist Date:_____
- ☐ Heart Surgery Date:_____
- ☐ Knee / Foot / Ankle Date:_____
- ☐ Hysterectomy Date:_____

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☐ Mastectomy Date:_____ ☐ Oral Surgery Date:_____

☐ Rhinoplasty Date:_____ ☐ Spinal Surgery Date:_____

☐ Other: _____

Family Medical History

☐ Autoimmune	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Allergies	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Alzheimer's	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Arthritis	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Asthma	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Bleeding Disorder	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Depression	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Diabetes	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Heart Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Kidney Disorder	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Psychological Disorder	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Thyroid Disorder	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent

Social History:

☐ Alcohol Use	☐ Never	☐ Weekly	☐ Monthly	☐ Less than Monthly	☐ Daily
☐ Caffeine Use	☐ Never	☐ Weekly	☐ Monthly	☐ Less than Monthly	☐ Daily
☐ Marijuana Use	☐ Never	☐ Daily	☐ Occasional	☐ Social	
☐ Other Drug Use	☐ Daily	☐ Occasional	☐ Social		
☐ Tobacco Use:	☐ Current	Packs Per Day: _____			
	☐ Former	Quit Approx: _____			

Living Environment

☐ Animal Exposure	☐ Dust Exposure	☐ Mold Exposure
☐ Air-Conditioning	☐ Home Windows Open	☐ 2nd Hand Smoke Exposure

Height:_____ Weight:_____

Allergies to Medications:

_____ _____ _____

_____ _____ _____

Medication List:

_____ _____ _____

_____ _____ _____

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_____ _____ _____

Signature: _____ Date: _____