Sinus Solutions AT IMMUNOe

Patient History

Patient Name: _____
Date of Birth: _____
Date: _____

Please complete this form to the best of your ability. This will allow our office to treat you appropriately. As your medical history may change, you may be asked to update this form on a regular basis to help us provide the best medical care.

Reason for visit today: _____

Referring Physician: _____ **Primary Care Physician:** _____

Preferred Pharmacy: _____ **Pharmacy Phone:** _____

Past Medical History:

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

Surgical History:

□ Sinus Surgery	Date:_____	□ Turbinate Reduction	Date:_____	□ Hysterectomy	Date:_____
□ Septoplasty	Date:_____	□ Esophageal Dilation	Date:_____	□ Knee / Ankle	Date:_____
□ Tonsillectomy	Date:_____	□ Appendectomy	Date:_____	□ Oral Surgery	Date:_____
□ Adenoidectomy	Date:_____	□ Colonoscopy	Date:_____	□ Spinal Surgery	Date:_____
□ Tymp & Tubes	Date:_____	□ Eye Surgery	Date:_____	□ Hernia Repair	Date:_____
□ Mastoidectomy	Date:_____	□ Gallbladder	Date:_____	□ Hip Surgery	Date:_____
□ Fundoplication	Date:_____	□ Hand / Wrist	Date:_____	□ Mastectomy	Date:_____
□ Thyroid Surgery	Date:_____	□ Heart Surgery	Date:_____	□ Rhinoplasty	Date:_____
□ C-Section	Date:_____	□ Other: _____			

Family Medical History

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

□ Other: _____

Social History:

□ Alcohol Use	□ Caffeine Use	□ Marijuana Use	□ Other Drug Use	□ Regular Exercise
□ Tobacco Use:	□ Never	□ Current: packs per day_____		□ Former: quit _____

Living Environment

□ Animal Exposure	□ Dust Exposure	□ Mold Exposure	□ 2nd Hand Smoke Exposure
□ Air-Conditioning	□ Home Windows Open	□ Swamp Cooler	□ Chemical Exposure

Signature: _____ **Date:** _____