Cleveland Head and Neck Clinic

Today's Date_____

Patient Name_____ Date of Birth_____

Name of favorite pharmacy, address, and phone number_____

I. History

1. Chief complaint (Why you are here today?) _____
   _____
   _____

2. History of the Illness:
   a) Location/When did it start?_____
      _____
   b) Quality of the Problem (Sharp or Dull pain?)_____
   c) Severity (Mild, Moderate, or Severe) _____
   d) Timing (During exercise, at night, gets worse in the spring, etc.) _____
      _____
   e) Context (Worsening, Recurrent) _____
   f) What makes it better (Heat, Cold, Rest, Antihistamines, etc.) _____
      _____
   g) Associated Symptoms_____

II. **Past History** Height _____ Weight _____

1. Illnesses (High blood pressure, diabetes, etc.) Please List _____
   _____
2. Operations? No Yes Please List _____
   _____
3. Current Medications? No Yes Please List _____
   _____
4. **Allergies to Medications? No Yes Please List** _____
   _____
5. **Allergic to Latex? No Yes** _____
6. Family History (Medical Events, Heredity) _____
7. **If female, are you pregnant? No Yes**
8. Social History
   a) Smoking No Yes How Much? _____
   b) Chewing Tobacco No Yes How Much? _____
   c) Alcohol Use No Yes How Much? _____

III. **Review of Systems**

	Do you have any problems with any of the following? Yes	No	If yes, Explain
Eyes	_____	_____	_____
Lungs	_____	_____	_____
Heart	_____	_____	_____
Skin	_____	_____	_____
Stomach/Intestines	_____	_____	_____
Kidney/Bladder	_____	_____	_____
Blood/Bleeding/Lymph Nodes	_____	_____	_____
Immune System	_____	_____	_____
Muscle/Bones/Joints	_____	_____	_____
Allergies (Hay Fever, Etc.)	_____	_____	_____
Neurologic	_____	_____	_____
Psychiatric	_____	_____	_____
Weight gain or loss	_____	_____	_____

Other complications: _____
_____
_____

For office use only:

Vital Signs: Temp: _____ B/P: _____ Pulse: _____