

Name	MRN	DOB	Date
Telephone H	W	M	
Pharmacy Name	Telephone		
How did you hear about us? <input type="checkbox"/> Sent by another physician (If so, please give name below.) <input type="checkbox"/> Sent by a friend <input type="checkbox"/> Internet search <input type="checkbox"/> UT reputation <input type="checkbox"/> Other ( <i>Specify</i> )			
Physician #1 ( <input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	
Physician #2 ( <input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	

### Important Note on Medical Records and Previous Imaging

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the nose and sinuses are very important. Please try to obtain the actual films (not just the radiology reports); images on CD-ROM are preferable.

### START HERE:

**What symptom gives you the most trouble?**

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**Review of Systems**

The following is a list of common symptoms and health problems. Please review the list and indicate with a check mark the symptoms and health problems that you are experiencing.

	Yes	No	Treated by another physician
<b>General</b>			
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fevers/chills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Ears, Nose &amp; Throat</b>			
Hoarseness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Draining ear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vertigo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daytime sleepiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mouth sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tooth problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painful/difficult swallowing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ringing in the ears	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Eyes</b>			
Double vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurry vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Cardiac</b>			
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Short of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Respiratory</b>			
Wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Yes	No	Treated by another physician
<b>Gastro-intestinal</b>			
Heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Belly pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Skin</b>			
Rashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Musculo-skeletal</b>			
Muscle pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Endocrine</b>			
Cold intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heat intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive thirst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Hematologic</b>			
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bruising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Neurological</b>			
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Psychiatric</b>			
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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**Past History**

Do you have any of the following medical problems?

- Arthritis
- Asthma
- Bleeding disorder
- Cataracts
- Chronic fatigue syndrome
- Depression
- Diabetes
- Fibromyalgia
- Gastritis
- Glaucoma
- Hepatitis
- High blood pressure
- Heart disease
- Immunodeficiency
- Kidney disease
- Meningitis
- Migraine headache
- Mitral valve prolapse
- Peptic ulcer disease
- Seizures
- Thyroid disease
- Tuberculosis (TB)

Please list your previous surgical procedures.

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?

- Yes
  - No
- (If yes, please give details.)*

Please list your current medications.

Are you allergic to any medications?

- Yes
  - No
- (If yes, please give details.)*

**Family History**

Do any of your family members have any of the following conditions?

- Allergy
- Asthma
- Bleeding disorder
- Cancer
- Cystic fibrosis
- Heart disease
- Immunodeficiency

**Social History**

What is your occupation?

Have you had any recent change in your home or work environment? Details

- Yes
- No

Do you smoke? Details

- Yes
- No

Do you drink alcoholic beverages? Details

- Yes
- No

Have you ever used cocaine or other illicit substances? Details

- Yes
- No.