PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION TO THE BEST OF YOUR ABILITY:

Patient's Name: _____ Date of Birth: _____Age:_____
Occupation: _____ If retired, what was your occupation: _____
Height: _____Weight: _____
What problems are you here for today? _____
_____
How long have you had the symptoms? _____
List any Allergies to Medications: _____

PAST MEDICAL HISTORY: Please check the "Yes" or "No" box to indicate if you have any of the following illnesses for "Yes" answers, please explain:

Diabetes	**Yes__ No__**	**_____**
High blood pressure	**Yes__ No__**	**_____**
Thyroid problems	**Yes__ No__**	**_____**
Heart disease	**Yes__ No__**	**_____**
Cholesterol problems	**Yes__ No__**	**_____**
Respiratory problems	**Yes__ No__**	**_____**
Stomach or intestinal problems	**Yes__ No__**	**_____**
Allergy problems/therapy	**Yes__ No__**	**_____**
Kidney problems	**Yes__ No__**	**_____**
Neurological problems	**Yes__ No__**	**_____**
Other medical diagnosis	**Yes__ No__**	**_____**

Please list any and all of the operations & dates you have ever had: _____
_____
_____
Please list all hospitalization dates & conditions: _____
_____
_____
Please list any current medications (and amounts, times per day); Include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays, etc.) Please bring a list with you if more convenient.
_____
_____
_____

SOCIAL HISTORY:

Do you smoke? Yes__ No__ If yes, how many packs per day? _____For how many years? _____
If not, did you smoke previously? Yes__ No__ If yes, ___packs per day ___# of years _____date you quit
How often do you drink alcohol? _____
What type do you prefer? _____
What is your occupation? _____

FAMILY HISTORY: Please check the "Yes" or "No" to indicate whether any relatives have any of the following illnesses. If yes, please indicate which relative(s) have the problem:

Hearing problems	**Yes__ No__**	**_____**
Allergy	**Yes__ No__**	**_____**
Diabetes	**Yes__ No__**	**_____**
Cancer	**Yes__ No__**	**_____**
Bleeding disorder	**Yes__ No__**	**_____**
Anesthesia problems	**Yes__ No__**	**_____**
Heart problems	**Yes__ No__**	**_____**

What is the name of your family doctor? _____Town: _____
What doctor referred you to this office? _____
If a patient referred you to Dr. Kardos, what is the patient's name? _____

(Continue on page 2)

MEDICAL HISTORY FORM (page 2). PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION TO THE BEST OF YOUR ABILITY.

Patient's Name: _____

PAST MEDICAL HISTORY: Please write yes or no to indicate whether you presently have any of the following symptoms. For a "Yes" answer, please indicate "current" if this symptom relates to the reason for today's visit:

ALLERGY:	**_____sneezing**
	_____environmental allergy
	_____postnasal drip
ENT:	**_____ear pain or itch**
	_____hearing loss
	_____dizziness
	_____nasal congestion
	_____sense of smell problem
	_____hoarseness
	_____throat clearing
	_____ear drainage
	_____ear noises
	_____lightheadedness
	_____sinus pressure or pain
	_____problem snoring, apnea
	_____throat pain
	_____throat dryness/itching
HEME/	
LYM	**_____swollen glands**
	_____bleeding problems
	_____sweating at night
	_____easy bruising
GU:	**_____frequent urination**
	_____painful urination
PSYCH:	**_____depression**
	_____anxiety or panic
RESP:	**_____ cough**
	_____wheezing
	_____coughing blood
	_____shortness of breath
EYES:	**_____eye pain**
	_____watery or itchy eyes
GI:	**_____difficulty swallowing**
	_____heartburn
NEURO:	**_____headache**
	_____passing out
	_____weakness
	_____numbness, tingling
GENERAL:	**_____chills**
	_____fatigue
	_____weight loss or gain
	_____daytime sleepiness
ENDO:	**_____feel warmer than others**
	_____feel cooler than others
CARDIAC:	**_____chest pain**
	_____palpitations
MSK:	**_____joint aches**
	_____muscle aches
SKIN:	**_____rash**
	_____itching
	_____hives
	_____skin changes
	_____hair changes

USE SPACE BELOW TO ELABORATE: _____
_____
_____
_____

AFTER THE TWO PAGES OF THIS FORM HAVE BEEN COMPLETED, PLEASE SIGN YOUR NAME BELOW

Signature X_____ Today's Date:_____

Reviewed by:_____

s