Patient Information:

Reason for Visit_____
Referring Physician:_____
Pharmacy name and phone number: _____
Email address: _____Phone Number_____
Occupation & Employer:_____
Employment status: Full-time_____ Part-time_____Retired_____Unemployed_____
Marital Status: ☐ Married ☐ Divorced ☐ Single
Could you be pregnant? ☐ YES/How many months?_____ ☐ NO

Medical History:

Allergic Rhinitis	_____	Seizures	_____	Thyroid disease	_____	Heart Disease/MI	_____	Hepatitis	_____
Asthma /COPD	_____	Sinus disease	_____	Tuberculosis	_____	Hypertension	_____	Kidney disease	_____
GERD	_____	Sleep apnea	_____	Cancer/type	_____	Depression	_____	Renal failure	_____
Hearing loss	_____	Strep throat	_____	Diabetes	_____	HIV/AIDS	_____		
Otitis Media	_____	Stroke	_____	Bleeding disorders	___	Liver Disease	_____		

Other Medical History:_____
_____

Surgical History:	**DATE**		**DATE**		**DATE**
Adenoidectomy	_____	Thyroid surgery	_____	Lung surgery	_____
Brain surgery	_____	Tonsillectomy	_____	Ear surgery	_____
Cosmetic surgery	_____	Heart Surgery	_____	Transplant	_____
Sinus surgery	_____	Neck Surgery	_____		

Other Surgical History: _____

Family History: (Please check all that apply to your family members):

allergy_____	cystic fibrosis_____	sinus disease_____
asthma _____	stroke_____	heart disease_____
high blood pressure_____	bleeding disorder_____	cancer_____
diabetes_____	other_____	

Allergies/Contraindications:_____
No Known Allergies
_____
_____

Medications:
_____
_____
_____

Social History:

Tobacco Use: YES/start date_____ NO Quit/Date_____ Packs/Day _____
Years:_____ Counseling given Y/N
Smokeless Tobacco: Current____Former_____Never_____ Unknown_____Quit/Date_____Ready to Quit Y/N
Alcohol Use: Y/N Alcohol/week
Glasses of wine_____Cans of beer_____Shots of liquor_____Drinks Containing 0.5 oz alcohol_____
Comments: _____
Substance Use: Y/N Use/Week_____Types/Comment:_____

Because so many people deal with fear and abuse in their relationships, we ask these same questions of all our patients
Beacon Program : 919-966-9314
Does your partner/caregiver ever threaten or try to control you? _____YES_____NO
Is abuse, violence, or sexual assault a problem for you in anyway?_____YES_____NO

continue on back

Review of symptoms: (Check any of the following which you have now or have experienced in the past):

GENERAL
_____Nausea
_____recent weight gain/loss
_____fatigue
_____fever/chills/night sweats

EARS
_____ringing
_____hearing loss
_____dizziness/vertigo
_____pain
_____ _____ drainage

SLEEP DISTURBANCE
_____loud snoring
_____excessive sleepiness
_____difficulty falling asleep
_____breathing stops during sleep
_____wake up feeling unrested

MOUTH/THROAT
_____dryness
_____soreness
_____ulcers
_____difficulty swallowing
_____lumps in neck
_____painful swallowing
_____hoarseness
_____choking

NERVOUS SYSTEM
_____numbness
_____tingling
_____fainting
_____weakness

EYES
_____recent worsening vision
_____clouded vision
_____dry eyes
_____double vision

CARDIOPULMONARY
_____heart murmur
_____palpitations
_____chest pain
_____shortness of breath
_____wheezing
_____chest tightness

GASTROINTESTINAL
_____indigestion/heartburn
_____vomiting
_____change in stool color
_____diarrhea/constipation
_____abdominal pain

PSYCHOLOGICAL
_____ _____ schizophrenia
_____ _____ depression

ENDOCRINE
_____heat/cold intolerance
_____excessive thirst
_____change in shoe/hand size

Nursing Assistant:

BP: ____/_____ Weight (kg):_____ Height (in):_____ Pulse:_____Temp:_____Resp:_____

Pain: 0 1 2 3 4 5 6 7 8 9 10