PLEASE COMPLETE IN BLACK INK.

For Office Use Only
MRN_____
DATE_____
HT_____
WT_____
BP_____
HR_____
RR_____
Pulse Ox_____

500 South University ● Suite 215 ● Little Rock, AR 72205
● Phone 501-420-1085 ● Fax 501-420-1457

Patient Name _____ _____ _____
First **Middle** **Last**

Date of Birth _____ **Sex** □ **M** □ **F** **Age** _____
Month Date Year

How did you hear about our clinic? (Check all that apply.)

□ Physician (Name: _____) □ Family/friend (Name: _____)

□ Internet/Website □ Yellow Pages □ Facebook □ Google

□ Insurance Directory □ Television □ Magazine/Newspaper Ad

□ Other:_____

List other family members seen by Dr. Graham: _____

_____ _____

_____ _____

Referring Physician_____

Primary Care Physician_____

Other Physician/s you wish to receive office visit letter: _____

CHIEF COMPLAINT

Please explain the MAIN reason for your visit. _____

_____

How long have you been experiencing this problem? _____

For Office Use Only. Doctor's Notes:

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name_____

NASAL/HEAD SYMPTOMS (Check all that apply.) □ **N/A**

□ itchy eyes	□ sneezing	□ frequent ear infections	□ nasal polyps
□ watery eyes	□ posterior nasal drip	□ sore throat	□ throat clearing
□ dry eyes	□ snoring	□ itching of throat	□ sinus infections
□ dark circles under eyes	□ sleep apnea	□ hoarseness	□ nose bleeds
□ itchy nose	□ CPAP	□ sinus pressure	□ headaches
□ nasal congestion	□ ear pressure	□ cough	□ loss of taste
□ runny nose	□ dizziness	□ roof of mouth itching	□ loss of smell

At what age did you first experience these symptoms? _____

When do you experience these symptoms? (Check all that apply.)
□ Year round □ Spring □ Summer □ Fall □ Winter

Do these symptoms interfere with daily life? □ Yes □ No

Severity of symptoms (Check all that apply.)
□ Mild □ Moderate □ Severe □ Worsening □ Stable

What are the triggers? What makes you worse? (Check all that apply.)
□ No Known Triggers

Allergens	**Irritants**	**Weather Changes**
□ grass pollen/cut grass	□ perfumes	□ cold weather
□ hay	□ strong scents	□ temperature changes
□ leaves	□ paint	□ hot humid weather
□ house dust	□ hair spray	□ rainy/damp weather
□ mold or mildew	□ outside dust	□ windy days
□ tree pollen	□ lying down	
□ weed pollen	□ tobacco smoke	
□ dogs	□ smoke	
□ cats	□ while eating	
□ other animals: _____		

Have you had previous allergy testing? □ Yes □ No Results of Skin Tests:_____

Results of Blood Tests:_____

What physician evaluated you and what year?_____ □ **N/A**

Have you ever had allergy injections? □ Yes □No If so, how many years? _____ Prescribing physician _____

Are you currently taking injections? □ Yes □ No

Did your symptoms improve while on allergy shots? □Yes □No

Have your symptoms worsened since discontinuing injections? □Yes □No

Patient Name_____

HEADACHE SYMPTOMS □ N/A

How long have you had headaches? _____

How often do you get headaches? □ daily □ more than 2 times per week □ less than 2 times per week

How long do they last? _____

What do you do to relieve your symptoms? _____

Location? □ temple area □ forehead □ top of head □ back of head

Do you have any nausea or vomiting associated with your headaches? □ Yes □ No

Are you sensitive to light or sound? □ Yes □ No

RECURRENT INFECTIONS □ N/A

Number of ear infections: _____ in the past 12 months _____ total in lifetime

PE tubes: □ Yes □ No _____ # of sets

Number of sinus infections _____ in the past 12 months _____ total in lifetime

Number of pneumonias _____in the past 12 months _____ total in lifetime

Number of antibiotics in the last year _____

Names of antibiotics taken_____

Number of hospitalizations for infections _____ Type of infections _____Date/s_____

Have you had any lab to check your immune system? □ Yes Date _____ Lab/location_____ □ No

Have you had a previous ENT consultation? □ Yes Date _____ □ No

Name of ENT doctor _____

Date of last visit _____ Have you had a sinus x-ray? □ Yes Date _____ □ No

Have you had a sinus CT? □ Yes Date _____ □ No Sinus surgery? □ Yes □ No

CHEST SYMPTOMS □ N/A

What are your MAIN chest symptoms? (Check all that apply.)

□ cough □ shortness of breath □ chest tightness □ wheezing

□ chest congestion □ recurrent chest infections □ asthma

What age did these symptoms begin? _____

Was first episode of wheezing with RSV or bronchiolitis? □ Yes □ No

Has recurrent bronchitis been a problem? □ Yes □ No

How would you describe your symptoms? (Check all that apply.)

□ mild □ moderate □ severe □ stable □ worsening □ uncontrollable

Triggers- What makes you worse? (Check all that apply.) □ No Known Triggers

□ colds or infections □ exercise/exertion □ cold air □ laughing/crying

□ morning time □ nighttime □ perfumes/strong odors □ cats

□ hot or humid weather □ lying down □ stress/anxiety □ dust □ pollen

Are your symptoms worsened with seasons? (Check all that apply.)

□ spring □ fall □ summer □ winter □ year round

CHEST SYMPTOMS, cont.

How many days per month is your sleep disturbed by your chest symptoms? _____

How often do your chest symptoms interfere with normal activity? (Check all that apply.)

□ NONE □ minor □ some limitation □ extremely limited

How often do you use your rescue inhaler (Albuterol)? (Check all that apply.)

□ NONE □ Less than 2 days/week □ More than 2 days/week but not daily □ Daily □ Several times per day

Have you been to the emergency room for your CHEST symptoms? □ Yes Date(s)? _____ □ No

If yes, number of visits in the last 12 months? _____ Number in lifetime? _____

Have you been hospitalized for your CHEST symptoms? □ Yes □ No If yes, dates? _____

Number of times in the last 12 months? Number in lifetime? _____ □ ICU? □ Intubated?

Have you been treated with an inhaler or breathing machine (updraft)? □ Yes □ No

Have you been treated with:

□ Oral steroids ____# in the past 12 months ____ # in lifetime □ Steroid shots _____# in the past 12 months ____ # in lifetime

Have you had a chest x-ray? □ Yes □ No Date/s _____

Have you seen a pulmonologist? □ Yes □ No

If yes, name of physician: _____

SKIN SYMPTOMS/RASH □ N/A

Have you seen a dermatologist? □ Yes □ No If yes, physician? _____Date_____Biopsy? □ Yes □ No

Describe the appearance. (Check all that apply.)

□ red, rough patches □ itchy □ red bumps □ Other? _____

Location? _____How long has it been present? _____

ECZEMA (Dry, flaky, itchy, sensitive skin) □ N/A

Severity (Check all that apply.) □ Mild □ Moderate □ Severe □ Uncontrollable

When did it start? □ Infancy □ Childhood □ As an adult

Soap currently using: _____

Detergent currently using: _____

Lotions currently using: _____

Creams/Ointments used: _____

Is it worsening? □ Yes □ No Is it improving? □ Yes □ No Does it come and go? □ Yes □ No

Are there any known triggers? If so, list below. □ **No known triggers**

_____ _____ _____

Do foods make it worse? □ Yes □ No If yes, list foods:_____

Treatment used:_____

_____

Patient Name_____

HIVES/SWELLING □ **N/A** **(If swelling with no hives, go to the next box.)**

Do you have hive symptoms? □ Yes □ No

How long have you had hives? _____days _____weeks _____months _____years

When do the hives usually occur? □ early morning □ immediately after eating □ evening □ random □ middle of the night

How long are your hives present? □ less than an hour □ several hours □ more than 24 hours

Triggers – What makes it worse? (Check all that apply.)

□ heat □ cold □ exercise □ foods □ medications □ pressure □ unknown

Where do they occur on the body? (Check all that apply.)

□ face □ scalp □ extremities □ trunk □ entire body

Do you have any of these symptoms at the time of your hives? (Check all that apply.)

□ swelling □ wheezing □ fainting □ dizziness □ throat swelling □ bruising

□ vomiting □ diarrhea □ fever □ nausea □ joint symptoms

What treatments have you used?_____ With relief? □ Yes □ No

SWELLING □ **N/A**

Have you ever had swelling of the following? (Check all that apply.)

□ lips □ tongue □ face □ throat □ hands/arms □ legs/feet □ other

Does your swelling occur with hives? □ Yes □ No Have you had abdominal pain/cramping with swelling? □ Yes □ No

Have you been to the ER or hospitalized in the past year because of hives or swelling? □ Yes □ No Date/s: _____

If yes, please explain: _____

Have you taken oral steroids in the past year for hives or swelling? □ Yes □ No Steroid shot/s □ Yes □ No

Has a physician ordered any blood tests due to hives? □ Yes or No If so, what doctor? _____

When were the tests ordered? _____

What treatment/s have you used? _____Relief? □ Yes □ No

Is there a family history of swelling? □ Yes □ No

INSECT STING REACTIONS (If reacted at the sting site **ONLY**, do not complete!) □ **N/A**

Suspected insect(s) that caused the reaction? _____ Where was the insect? _____

At what age did the reaction occur? _____ # of reactions _____ Body location of stings? _____

How long after the sting did your symptoms occur? _____

Symptoms with reactions: (Check all that apply.)

□ local swelling □ shortness of breath □ wheezing □ passing out

□ hives(other than at sting site) □ feeling of impending doom □ swelling other than at site

How long did these symptoms last?_____

Treatment_____

ER visits for stings? □ Yes □ No # of ER visits _____

Do you have an Epi-Pen? □ Yes □ No Have you had an EpiPen? □ Yes □ No Have you used an EpiPen? □ Yes □ No

Patient Name_____

FOOD REACTIONS □ N/A

Circle the following foods tolerated in current diet: **milk egg peanut tree nuts fish shellfish soy wheat sesame**

Please explain, in detail, the suspected food, time after exposure, describe the reaction, any treatment of the reaction, length of the reaction and whether you had to go to the ER or the doctor's office for treatment. _____

_____

_____

Suspected food(s), reaction and symptoms of reaction? Below please explain each reaction separately.

Age/Date	Food	Time after ingestion that symptoms began	Symptoms of reaction	Treatment	Length of reaction	ER/MD Y or N	EpiPen Y or N

How many reactions have occurred? _____

Additional notes regarding reaction/s: _____

_____

_____

REFLUX SYMPTOMS □ N/A

Do you suffer from heartburn or indigestion? □ Yes □ No Do you have a history of reflux? □ Yes □ No

What medications are you taking to treat your symptoms?_____

What medications have you previously tried? _____

Do you have difficulty swallowing? □ Yes □ No Has food gotten stuck in your throat when swallowing? □ Yes □ No

Do you clear your throat or cough after eating? □ Yes □ No

Have you seen a Gastroenterologist? □ Yes □ No

Physician/s Name/s_____

EGD □ Yes □ No Date/s/age _____

Swallow Study: □ Yes □ No Date/s/age _____

Other Procedure/s _____ Date/s/age _____

Other Procedure/s _____ Date/s/age _____

Other Procedure/s _____ Date/s/age _____

Patient Name_____

DRUG ALLERGIES □ **No Known Drug Allergies**

List any medications that you are allergic to and the type of reaction you had:

_____

_____

_____

MEDICATIONS **PHARMACY (LOCAL)** _____ **MAIL ORDER**_____

Does your insurance require a 30 day supply of medications? □ **Or a 90 day supply?** □

Please list all medications including strength and dosage. Include over the counter meds.

ALLERGY or ASTHMA medications **CURRENTLY TAKING:**

Medication	**Strength**	**Dosage (when and how often)**

List any **OTHER** medications **PRESENTLY** taking including the dosage and strength:

Medication	**Strength**	**Dosage (when and how often)**

List any **PREVIOUS** allergy or asthma medications tried and the results:

Patient Name_____

PAST MEDICAL HISTORY (Please check all that apply.) □ Unknown

□ ADD (Attention Deficit Disorder)	□ Gallstones	□ Mitral valve prolapse
□ ADHD (Attention Deficit Hyperactivity Disorder)	□ GERD (reflux)	□ Nasal polyps
□ Anemia	□ Glaucoma	□ Pneumonia
□ Arthritis	□ Headaches	□ Psoriasis
□ Asthma	□ Heart disease	□ Recurrent bronchitis
□ Autism	□ Hepatitis	□ Rheumatoid arthritis
□ Blood clots	□ Hiatal hernia	□ RSV (Respiratory Syncytial Virus)
□ Cataracts	□ High blood pressure	□ Seizures
□ COPD	□ High cholesterol	□ Sinus infections, chronic or recurrent
□ Chronic ear infections	□ Hyperthyroidism	□ Sleep apnea
□ Congestive heart failure	□ Hypoglycemia	□ Stroke/TIA
□ Diabetes	□ Hypothyroidism	□ Tuberculosis
□ Eczema	□ Irritable bowel syndrome	
□ Fibromyalgia	□ Lupus	
	□ Ulcerative colitis	

Cancer □ **Yes** □ **No** **Type** _____ **Year**_____

Treatment: □ **Chemotherapy** □ **Radiation** □ **Surgery**

Illnesses not listed: _____ _____ _____

HOSPITALIZATIONS

Reason _____ Date_____

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

ALLERGIC FAMILY HISTORY (Please check IMMEDIATE family who have a history of the following.) □ Unknown

Asthma: □ Mother □ Father □ Sister □ Brother □ Daughter □ Son

Allergic rhinitis: □ Mother □ Father □ Sister □ Brother □ Daughter □ Son

Sinus problems: □ Mother □ Father □ Sister □ Brother □ Daughter □ Son

Nasal polyps: □ Mother □ Father □ Sister □ Brother □ Daughter □ Son

Eczema: □ Mother □ Father □ Sister □ Brother □ Daughter □ Son

Hives: □ Mother □ Father □ Sister □ Brother □ Daughter □ Son

Food allergy: □ Mother □ Father □ Sister □ Brother □ Daughter □ Son

GENERAL FAMILY HISTORY – In your generation or the generation before you, are there any of the following? (Check all that apply.)

□ Arthritis	□ Cancer	□ Heart Disease	□ Hypertension
□ Diabetes	□ Emphysema	□ Migraine	□ Lupus
□ Kidney disease	□ Seizures	□ Thyroid disease	□ Tuberculosis
□ Cystic Fibrosis	□ Alpha-one antitrypsin deficiency		

Other illnesses not listed: _____ □ **Unknown**

SURGICAL HISTORY □ Unknown

Tonsillectomy □ Yes Date _____

Adenoidectomy □ Yes Date _____

PE tubes □ Yes _____ Date(s) Number of sets _____

Polypectomy (nasal polyp removal) □ Yes Date_____ Septoplasty (nasal bone repair) □ Yes Date _____

Sinus Surgery □ Yes _____ Date Type:_____

Other Surgeries _____

_____

Patient Name_____

PEDIATRIC HISTORY (For patients 0-12 years of age) □ Unknown

Birth weight: _____lbs _____oz
Was birth premature? □ Yes If yes, how many weeks **early**? _____ □ No
RSV before 3 months of age? □ Yes □ No
Reflux as an infant? □ Yes □ No
Multiple formula changes? □ Yes □ No

SOCIAL HISTORY

City of residence _____ Hometown _____
Most recent occupation _____
Types of work done in past _____
Workplace Exposures - Please list. _____
If a child, grade in school: _____

ENVIRONMENTAL REVIEW (Check all that apply.)

□ Apartment
□ House
□ Mobile home
□ Gas/Propane Heat
□ Electric heat
□ Space heater
□ Wood burning fireplace
□ Central air conditioning
□ Window air conditioner

□ Birds
□ Cat indoors
□ Cat outdoors
□ Dog indoors
□ Dog outdoors
□ No pets
□ Other animals
List:_____
_____

□ Carpet in bedroom
□ No carpet in home
□ Feather pillow
□ Cotton pillow
□ Zipper encasing
□ Cotton mattress
□ Feather mattress/topper
□ Tobacco/Smoke Exposure/How often?_____
□ Family members smoke indoors
□ Family members smoke outdoors

SMOKING STATUS

_____Smoker _____ Non-smoker Are you exposed to tobacco smoke? □ Yes □ No
Current every day smoker/Age started: _____/How many per day? _____
Former smoker/ Age quit: _____How long did you smoke? _____
How many packs per day? _____
Do you use recreational drugs? □ Yes □ No If so, which ones?_____

Check the tobacco type used.
□ **Cigarettes**
□ **Cigars**
□ **Pipe**
□ **Chewing tobacco**
□ **Snuff**

Do you use alcohol? □ Yes □ No If yes, how much and how often?_____

IMMUNIZATION HISTORY

Are your immunizations up to date? □ Yes □ No
Did you receive your flu vaccine this year? □ Yes □ No If yes, when? _____
Have you received a pneumonia vaccine? □ Yes □ No If yes, when? _____
Have you received a tetanus booster in the last 10 years? □ Yes □ No

Patient Name_____

REVIEW OF SYSTEMS (Check the symptoms that you are currently experiencing.) ☐ **N/A**

GENERAL
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss

SKIN
- ☐ Dry skin
- ☐ Rash
- ☐ Itching
- ☐ Hives

HEENT
- ☐ Dry eyes
- ☐ Itchy eyes
- ☐ Watery eyes
- ☐ Glaucoma
- ☐ Glasses/Contacts
- ☐ Good vision
- ☐ Nasal drainage
- ☐ Nasal congestion
- ☐ Nasal polyps
- ☐ Sinus pressure
- ☐ Sinus pain
- ☐ Runny nose
- ☐ Sneezing
- ☐ Headache
- ☐ Ear infection
- ☐ Earache
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Oral ulcers
- ☐ Snoring
- ☐ Sleep apnea
- ☐ CPAP

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Sputum production
- ☐ Wheezing
- ☐ Decreased exercise tolerance

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Swelling of extremities
- ☐ Difficulty breathing lying down
- ☐ Irregular heartbeat

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Bloody stools

NECK
- ☐ Neck mass
- ☐ Swollen glands

MUSCULOSKELETAL
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Muscle weakness

NEUROLOGICAL
- ☐ Stroke
- ☐ Tremor
- ☐ Dizziness

PSYCHIATRIC
- ☐ Confusion
- ☐ Anxiety
- ☐ Depression

ENDOCRINE
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Thyroid problems

HEMATOLOGY
- ☐ Anemia
- ☐ Nose bleeds
- ☐ Easy bruising

For Office Use Only

Reviewed by physician:

_____

D. Melissa Graham, M. D.

_____

Date