

PATIENT MEDICAL AND SOCIAL HISTORY

RUSSELL T. SNOW, D.O., P.A.

Date: _____

Name: _____ Date of Birth: _____ Age: _____ M or F _____

Marital status: PLEASE CIRCLE Occupation-Current and former: _____

Child Single Divorced Married Widowed

Referring Physician: _____ Primary Physician: _____

Reason for Visit (Describe ALL Pertinent Symptoms and Date of Onset):

Past Medical History: (list all medical diagnoses) _____

Previous Surgeries: _____

Have you or a **biological** family member had complications with anesthesia? No Yes Explain: _____

Name:	Strength: (e.g. 500mg tablets)	Dose: (e.g. 1 tablet 2 times daily)
NONE _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies: None Known _____ Yes (Explain: Name and reaction) _____

Patient Social History:
Use of alcohol: Never: _____ Type/Frequency: _____ Quit when? _____
Use of tobacco: Never: _____ Current packs/day: _____ How long? _____ yrs. Prior use packs/day: _____ Started? _____ Quit? _____
Smokeless Tobacco? Type: _____ Amount: _____ How long: _____ Quit when? _____
Use of recreational drugs: Never: _____ Type/Frequency: _____ Quit when? _____

Hearing Loss? No: _____ Yes: _____ Right ear _____ Left ear _____ Both ears _____ How long? _____

Noise Exposure History (sources, how long): _____

Has any blood relative had hearing loss prior to age 65? No or Yes Type: _____

Family History: (Biological Family Members only)

	IF LIVING: Current <u>Age</u> and Medical Problems or Illnesses	IF DECEASED: Age at Death/Cause
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
Sisters	_____	_____

Other Family Illnesses: _____

Dr. Initials/Date: _____/_____/_____

Dr. Reviews: _____/_____/_____ _____/_____/_____ _____/_____/_____

Russell T. Snow, D.O.

Systems Review

List only **CURRENT** abnormal conditions unless designated as history

1) General Constitution	Yes	No	Comment
Weight change, recent over 10 lbs	()	()	_____
Fevers	()	()	_____
Night sweats/Chills	()	()	_____
General ill feeling	()	()	_____

2) Eyes	Yes	No	Comment
Recent change in vision	()	()	_____
Eye pain	()	()	_____
Eye drainage	()	()	_____
Watering or itching	()	()	_____

3) ENT and Mouth	Yes	No	Comment
Hearing loss, recent or previous?	()	()	_____
Ear pain or drainage	()	()	_____
Noise in ears (ringing, buzzing etc.)	()	()	_____
Nasal bleeding	()	()	_____
Nasal drainage (runny nose) (color?)	()	()	_____
Nasal congestion, breathing difficulty	()	()	_____
Sense of smell, absent or poor?	()	()	_____
Snoring problem	()	()	_____
Long breathing pauses during sleep	()	()	_____
Daytime sleepiness	()	()	_____
Facial pain	()	()	_____
Teeth aching or painful	()	()	_____
Sore throat	()	()	_____
Bad breath	()	()	_____
Hoarseness	()	()	_____
Choking on food or fluid	()	()	_____
Difficulty swallowing	()	()	_____
Painful swallowing	()	()	_____
Lump sensation in throat	()	()	_____
Lump or swelling in neck or jaw	()	()	_____
Open sores in nose, mouth or throat	()	()	_____

4) Cardiovascular	Yes	No	Comment
Heart attack history	()	()	_____
Heart surgery history	()	()	_____
High blood pressure	()	()	_____
Chest pain (angina) history	()	()	_____
Irregular heart beat	()	()	_____
Leg ulcers or swelling	()	()	_____

5) Respiratory	Yes	No	Comment
Persistent cough	()	()	_____
Cough up blood	()	()	_____
Shortness of breath	()	()	_____
Wheezing	()	()	_____

6) Gastrointestinal	Yes	No	Comment
Nausea or vomiting	()	()	_____
Diarrhea	()	()	_____
Abdominal pain	()	()	_____
Heartburn, frequent	()	()	_____
Bloody vomiting	()	()	_____
Bloody or black stool	()	()	_____

7) Genitourinary	Yes	No	Comment
Congenital kidney disease, history	()	()	_____
Painful/Bloody urination	()	()	_____

8) Musculoskeletal	Yes	No	Comment
Painful or swollen joints	()	()	_____
Arthritis	()	()	_____
Other rheumatoid diseases, history	()	()	_____
Chronic TMJ (jaw joint) problem	()	()	_____

9) Skin/Scalp Face, Head or Neck	Yes	No	Comment
Non-healing sores	()	()	_____
Lumps, bumps, thick spots	()	()	_____
Red/flaking spots or patches	()	()	_____
Brown or black spots or patches	()	()	_____

10) Neurological	Yes	No	Comment
Frequent or severe dizziness	()	()	_____
Imbalance, chronic or recurrent	()	()	_____
Seizure/Epilepsy history	()	()	_____
Numbness in face, head or neck	()	()	_____
Weakness/Paralysis face or neck	()	()	_____
Headaches, chronic or recurrent	()	()	_____

11) Psychiatric	Yes	No	Comment
Depression	()	()	_____
Stress/Anxiety	()	()	_____

12) Endocrine	Yes	No	Comment
Thyroid disease	()	()	_____
Diabetes	()	()	_____

13) Hematological/Lymphatic	Yes	No	Comment
Bleeding disorder	()	()	_____
Anemia/Other blood disease	()	()	_____
Taking Aspirin or other blood thinner	()	()	_____
High Cholesterol	()	()	_____
Enlarged glands in head, neck or face	()	()	_____

14) Allergic/immunologic	Yes	No	Comment
Sneezing	()	()	_____
Environmental allergy symptoms	()	()	_____
AIDS or HIV positive	()	()	_____
Tetanus vaccine, date of last dose	()	()	_____

15) Women Only	Yes	No	Comment
Pregnant now	()	()	_____
Birth control, type	()	()	_____

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so or by court order.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my (my child's) health. It is my responsibility to inform Dr. Snow's office of any changes in my (my child's) medical status.

Print Patient's Name: _____
PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

Dr. Initials/Date
 /

Dr. Reviews
 _____/
 _____/
 _____/