

Kenneth Zuckerman, M.D., F.A.C.S.
 BOARD CERTIFIED OTOLARYNGOLOGY/HEAD & NECK SURGERY
 16300 SAND CANYON AVE. SUITE 704
 IRVINE, CALIFORNIA 92618
 (949) 753-0112

CLINICAL HISTORY FORM-Part 1

First Name: _____ Middle: _____
 Last: _____
 SSN: _____ - _____ - _____ Date of Birth: ____/____/____ Gender: MALE FEMALE
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: () _____ - _____ Day Phone: () _____ - _____ Referred by: _____
In case of emergency please list a contact person: First Name: _____ **Phone Number:** () _____ - _____
Address: _____
 Preferred Pharmacy: _____ City: _____ X Street _____
 Email address: _____

CHIEF COMPLAINT

Reason(s) for Visit:
 1. _____
 2. _____
Location(s): _____ **Historian:** _____
Onset: days weeks months years
Duration: 15 mins. 30 mins. 1hr. 2hrs. Variable _____
Frequency: Intermittent Occasional Constant Random
Status: improving unchanged worsening resolved
Severe of Symptoms: mild moderate severe incapacitating
Comments:

ALLERGIES (Select any allergies & document reactions)

No Allergies

<input type="checkbox"/> Accupril (quinapril) <input type="checkbox"/> Acetaminophen <input type="checkbox"/> Advil (Ibuprofen) <input type="checkbox"/> Ampicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Augmentin (amoxicillin) <input type="checkbox"/> Bactrim (sulfamethoxazole) <input type="checkbox"/> Biaxin <input type="checkbox"/> Ceclor (cefactor) <input type="checkbox"/> Celebrex <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Cipro (ciprofloxacin) <input type="checkbox"/> Clinoril (sulindac)	<input type="checkbox"/> Codeine <input type="checkbox"/> Contrast Media (Ioversol) <input type="checkbox"/> Coumadin <input type="checkbox"/> Darvon <input type="checkbox"/> Demerol <input type="checkbox"/> Depakote <input type="checkbox"/> Diamox <input type="checkbox"/> Dicloxacillin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Egg <input type="checkbox"/> Erythromycin <input type="checkbox"/> Flagyl <input type="checkbox"/> Floxin	<input type="checkbox"/> Heparin <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Inderal (propranolol) <input type="checkbox"/> Indocin (indomethacin) <input type="checkbox"/> Insulin (animal) <input type="checkbox"/> Iodine or shellfish <input type="checkbox"/> Keflex (cephalexin) <input type="checkbox"/> Lasix (furosemide) <input type="checkbox"/> Latex <input type="checkbox"/> Lidocaine <input type="checkbox"/> Lipitor <input type="checkbox"/> Micronase (glyburide) <input type="checkbox"/> Minocin (minocycline)	<input type="checkbox"/> Morphine <input type="checkbox"/> Motrin (ibuprofen) <input type="checkbox"/> Naprosyn (naproxen) <input type="checkbox"/> Niacin <input type="checkbox"/> Oxycodone <input type="checkbox"/> Peanut <input type="checkbox"/> Penicillin <input type="checkbox"/> Percocet (oxycodone) <input type="checkbox"/> Plavix <input type="checkbox"/> Phenytoin <input type="checkbox"/> Quinolones <input type="checkbox"/> Ranitidine <input type="checkbox"/> Septra (sulfamethoxazole)	<input type="checkbox"/> Sulfa <input type="checkbox"/> Tagamet (cimetidine) <input type="checkbox"/> Tegretol (carbamazepine) <input type="checkbox"/> Tetanus toxiod <input type="checkbox"/> Tetracycline <input type="checkbox"/> Valium (diazepam) <input type="checkbox"/> Vancomycin <input type="checkbox"/> Zithromax Other: _____ Reactions: _____
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MEDICATIONS (List any medications you are currently taking)

No Medications

Drug Name	Dosage	Frequency	Status: Chronic, Acute, Discontinued

