PATIENT HISTORY FORM

TODAY'S DATE __/____/_____ **DATE OF BIRTH__/____/_____**

LAST NAME_____ **FIRST NAME_____**

CHIEF COMPLAINT:
What is the main reason for your visit today? (Describe your problem in detail)

_____
_____
_____
_____
_____
_____

HISTORY OF PRESENT ILLNESS

PLEASE CIRCLE THE SYMPTOMS THAT YOU HAVE:

SNEEZING	ITCHY EYES
WATERY EYES	NASAL CONGESTION
COUGHING WITH EXERCISE	POST NASAL DRIP
COUGHING WITHOUT EXCERSICE	ITHCY EARS
RUNNY NOSE	ITCHY PALATE
HIVES	

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

Spring	Summer
Fall	All year

How long does this problem last?

30 min 1 hour It is always there
Other_____

Is anything else occurring at the same time? Yes No

Nausea Rash Headaches Other_____

Does the problem interfere with your normal functions? Yes No

If yes, please explain_____