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| --- | --- | --- |
|  | **A close up of a sign  Description automatically generatedA close up of a map  Description automatically generatedTHOMAS IRWIN M.D.,**  **GREGORY PIPPIN, M.D.,**  **ADIL FATAKIA, M.D., M.B.A.** |  |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: Age: \_\_\_\_\_\_\_\_ Sex: M/ F PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History:** □ NONE

□ Allergies □ Cancer □ Diabetes □ Migraines

□ Asthma □ Heart Disease □ Bleeding Disorder □ Sleep Apnea

□ Hearing Loss □ Hypertension □ Autoimmune disease □ HIV positive

□ Sinus □ Stroke □ Kidney Disease □ Seizures

□ Thyroid □ Cholesterol □ Hepatitis □ Other:

□ Nasal Polyps □ Bronchitis □ Emphysema \_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:** □ NONE

□ Sinus/Nose □ Ear Tubes □ Tonsillectomy/Adenoidectomy □ Thyroid

□ Appendectomy □ Heart Surgery □ Pacemaker/Defibrillator □ Hysterectomy

□ Gallbladder □ Breast Augmentation □ Facial Plastic

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** □ NONE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**

□ NONE □ Penicillin □ Sulfa □ Codeine □ Latex □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** □ NONE

Please check the box if any of the following diseases are common **in your family** or have occurred in any family member.

□ Allergies □ Cancer □ Diabetes □ Migraines

□ Asthma □ Heart Disease □ Hearing Loss □ Other:

□ Autoimmune Disease □ Stroke □ Bleeding Disorder \_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Tobacco Use: \_\_\_\_\_ Yes \_\_\_\_\_\_No Usage: <1 pack/day 1 pack/day >1 pack/day

Alcohol Consumption: \_\_\_\_\_ Yes \_\_\_\_\_\_No Daily 1-2 drinks/week 1-2 drinks/month 1-2 drinks/year

History of Substance Abuse: \_\_\_\_\_ Yes \_\_\_\_\_\_No If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational Drugs: \_\_\_\_\_ Yes \_\_\_\_\_\_No If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Parent Signature: Date: