



THOMAS IRWIN, M.D.
GREGORY PIPPIN, M.D.
ADIL FATAKIA, M.D., M.B.A.



Name: _____ Date of Birth: _____

Phone #: _____ Age: _____ Sex: M/ F PCP: _____

Medical History: NONE

- | | | | |
|---------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema | |

Surgical History: NONE

- | | | | |
|---------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Sinus/Nose | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Tonsillectomy/Adenoidectomy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Facial Plastic | |
| <input type="checkbox"/> 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.

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> 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: _____