

Patient History Form

Wenfu Chen M.D.

This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization.

(Please print all answers)

Today's Date: ____/____/____

Date of Last Physical Exam ____/____/____

Last Name _____ First Name _____ Middle _____

Age _____ Height _____ Weight _____

Chief Complaint

What is the main reason for your visit today? (Please describe your problem in detail)

Describe Your Present Illness

1. Location of problems (circle the areas):

Ear Sinus Throat Neck Other _____

2. How would you rate your illness on a scale of 1-10, with 10 as the most severe?

1 2 3 4 5 6 7 8 9 10

3. When did you first notice the problem?

2 days ago 2 weeks ago 4 weeks ago Other _____

4. Does anything help or make the problem worse? _____

5. How long does the problem last?

30 Minutes 1 Hour It is Always There Other _____

6. Do you have any other symptoms or illnesses occurring at the same time?

Yes No If yes, please explain _____

7. Is the problem constant or variable? _____

8. Does the problem interfere with your normal functions?

Yes No If yes, please explain _____

Past Medical and Social History

1. Are you allergic to any medications? Yes No

If yes, please explain: _____

2. Are you currently taking any medications? Yes No

If yes, please list all medications:

3. List any past illnesses, hospitalizations, and/or surgeries.

4. Do you smoke? Yes No

If yes, how much? _____ How long? _____

5. Do you drink socially? Yes No
 If yes, how much? _____ How long? _____
6. How many diet beverages do you consume daily? _____
7. Do you take any herbal or over-the-counter medications on a regular basis?
 Yes No
 If yes, please list all medications:

8. Do you use recreational drugs?
 Yes No
 If yes, please list:

Family Medical History

Does anyone in your immediate family have any of the following illnesses? Please circle Yes or No.

| | | | | | |
|---------------|-----|----|--------------------|-----|----|
| Hypertension | Yes | No | Abnormal Bleeding | Yes | No |
| Heart Disease | Yes | No | Hearing Loss | Yes | No |
| Stroke | Yes | No | Sinus Problems | Yes | No |
| Diabetes | Yes | No | Seasonal Allergies | Yes | No |

Review of Symptoms

Do you have or have you had any of the following problems? Please circle Yes or No.

EAR

| | | | | | |
|----------------------|-----|----|-----------------------------------|-----|----|
| Hearing Loss | Yes | No | Pressure/Fullness of the Ear | Yes | No |
| Ear ache | Yes | No | Tinnitus (Ringing in the ear) | Yes | No |
| Frequent infection | Yes | No | Fluctuation of hearing | Yes | No |
| Dizziness or Vertigo | Yes | No | Itching and Irritation of the Ear | Yes | No |

NOSE

| | | | | | |
|---|-----|----|----------------------|-----|----|
| Facial pain/pressure | Yes | No | Fever and Fatigue | Yes | No |
| Stiffness/Obstruction | Yes | No | Sinus headache | Yes | No |
| Nasal discharge/discolored postnasal drainage | Yes | No | Dental pain/cough | Yes | No |
| Decrease or loss of sense of smell | Yes | No | Sneezing and itching | Yes | No |

THROAT

| | | | | | |
|---------------------|-----|----|------------------------|-----|----|
| Chronic Sore Throat | Yes | No | Halitosis (bad breath) | Yes | No |
| Frequent Infection | Yes | No | Difficulty swallowing | Yes | No |
| Lump in the Throat | Yes | No | Hoarseness of voice | Yes | No |
| Snoring | Yes | No | Lymph gland swollen | Yes | No |

OTHER

Constitutional Symptoms

| | | |
|----------|-----|----|
| Fever | Yes | No |
| Chills | Yes | No |
| Headache | Yes | No |

Gastrointestinal

| | | |
|-----------------------|-----|----|
| Abdominal pain | Yes | No |
| Nausea/vomiting | Yes | No |
| Indigestion/heartburn | Yes | No |

Endocrine

| | | |
|----------------|-----|----|
| Diabetic | Yes | No |
| Too hot/cold | Yes | No |
| Tired/sluggish | Yes | No |

Eyes

| | | |
|-----------------|-----|----|
| Blurred Vision | Yes | No |
| Double Vision | Yes | No |
| Pain/discomfort | Yes | No |

Musculoskeletal

| | | |
|------------|-----|----|
| Joint pain | Yes | No |
| Neck pain | Yes | No |
| Back pain | Yes | No |

Integumentary

| | | |
|-----------------|-----|----|
| Skin rash | Yes | No |
| Boils | Yes | No |
| Persistent itch | Yes | No |

Cardiovascular

| | | |
|--------------------------------|-----|----|
| Chest pain | Yes | No |
| Varicose veins/swelling of leg | Yes | No |
| High blood pressure | Yes | No |

Genitourinary

| | | |
|--------------------|-----|----|
| Urine retention | Yes | No |
| Painful urination | Yes | No |
| Frequent urination | Yes | No |

Neurological

| | | |
|-------------------|-----|----|
| Tremors | Yes | No |
| Dizzy spells | Yes | No |
| Numbness/tingling | Yes | No |

Respiratory

| | | |
|---------------------|-----|----|
| Wheezing | Yes | No |
| Frequent Cough | Yes | No |
| Shortness of Breath | Yes | No |

Hematologic/Lymphatic

| | | |
|------------------------|-----|----|
| Swollen glands | Yes | No |
| Blood clotting problem | Yes | No |

Psychological

| | | |
|---|-----|----|
| Are you generally satisfied with your life? | Yes | No |
| Do you feel severely depressed? | Yes | No |
| Have you ever considered suicide? | Yes | No |

Thank you for filling out this form.