Lee A. Kleiman, M.D., F.A.C.S.

Patient Name: ________________________________ Date: ________________

Past Medical History and General Health Problems: Please check off if you have had any of the following

[ ] Asthma [ ] Diabetes Type 1 / Type 2 [ ] Seizures [ ] Kidney/Bladder

[ ] Arthritis [ ] Cardiac Problems: _________ [ ] Bleeding Disorder [ ] Stomach/Bowels

[ ] Hepatitis [ ] HIV [ ] Hypertension [ ] Psychiatric/Emotional

[ ] Stroke [ ] Cancer, Type: ___________ [ ] Neurological [ ] Muscles/Joints

[ ] Other, please list: ____

Surgical History: Please provide any previous surgeries and when they occurred.

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Social History: Occupation: ____

Marital Status (*please circle*) Single Married Divorced Widowed

Do you consume alcohol: NO YES How Often? ________________________

Do you smoke cigarettes: NO YES For how long: _________ Quit: ______

Do you consume caffeine: NO YES How much? ________________________

Family History: Please circle the appropriate response and provide significant medical history such Diabetes, Heart Disease, Hypertension, Cancer, etc.

Father: Alive Deceased Medical History: ________________________

Mother: Alive Deceased Medical History: ________________________

Siblings: Alive Deceased Medical History: ________________________

Alive Deceased Medical History: ________________________

Alive Deceased Medical History: ________________________

Medication List: Please provide the name and dosage of any medications you take.

Name of Medication	Dosage

Allergies to Medications: ____

Latex Sensitivity: YES NO

Review of Systems: Circle the symptoms you are most frequently experiencing.

Chest	Sinus	Nose	Throat	Eyes	Ears	Skin
Breathless	Infections	Sneezing	Sore	Itching	Itching	Itching
Wheezing	Pressure	Itching	Burning	Tearing	Infections	Hives
Cough	Pain	Runny	Postnasal Drip	Swelling	Popping	Eczema
Chest Tight	Headaches	Congestion	Trouble Swallowing	Infections	Pain	Swollen lips, tongue, or face
Heartburn		Decreased smell or taste	Hoarseness	Pain	Decreased Hearing	Psoriasis
		Bleeding		Vision Change	Dysequilibrium	
					Double Vision	

When do your symptoms occur? SINGLE OCCURANCE YEAR ROUND SEASONAL

Have your symptoms been treated with: (please circle below)

ANTIBIOTICS ANTIHISTAMINES DECONGESTANTS ALLERGY SHOTS INHALERS