ENT & ALLERGY
SERVING RHODE ISLAND FOR OVER 25 YEARS

SIRI The SINUS INSTITUTE of RHODE ISLAND

DATE: _____

NAME: _____ **DOB:** _____

CHIEF COMPLAINT | *The main reason(s) for your visit* _____

HISTORY OF PRESENT ILLNESS | *Describe the location, duration, severity, and timing of your main problem:*

_____

_____

List any associated symptoms: _____

What makes your problem(s) better? _____

What makes your problem(s) worse? _____

MEDICAL HISTORY | *Please check all that apply to you*:

[ ] High cholesterol	[ ] Kidney disease	[ ] Eye disease (glaucoma, etc.)	[ ] Head injury
[ ] High blood pressure	[ ] Thyroid disease	[ ] Skin disorders (eczema, etc.)	[ ] Facial trauma/fractures
[ ] Diabetes	[ ] Liver disease/hepatitis	[ ] COPD (bronchitis/emphysema)	[ ] Tuberculosis
[ ] Seizures	[ ] Psychiatric treatment	[ ] Obstructive sleep apnea (OSA)	[ ] CPAP user
[ ] Heart disease	[ ] Depression	[ ] Stroke or TIA ("mini-stroke")	[ ] HIV or AIDS
[ ] Anemia	[ ] Bleeding disorder	[ ] Autoimmune disease: _____	
[ ] Asthma	[ ] Lyme disease	[ ] Cancer: _____	
[ ] GERD ("acid reflux")	[ ] Immunodeficiency	[ ] Tumor/growth/cyst: _____	

[ ] Other: _____

SURGICAL HISTORY | *Please list **ALL** surgeries (including plastic surgery, tonsillectomy, etc.):*

Year	Procedure	Year	Procedure
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Do you **smoke (tobacco)** currently? [ ] Yes [ ] No
If yes, how many **packs per day**? _____
For how many years have you smoked? _____

Do you drink **alcohol** currently? [ ] Yes [ ] No
If yes, how many **drinks per week**? _____

Have you **ever smoked**? [ ] Yes [ ] No
If yes, when did you quit smoking? _____

Have you ever used "**recreational drugs**"? [ ] Yes [ ] No
If yes, please list: _____

Do you use **e-cigarettes**? [ ] Yes [ ] No
Do you use **chewing tobacco**? [ ] Yes [ ] No

What is your **occupation**? _____

NAME: _____ DOB: _____ DATE: _____

FAMILY MEDICAL HISTORY | *Please check all that apply to your **blood relatives**:*

[ ] Cancer
[ ] Heart disease
[ ] Stroke
[ ] Asthma
[ ] Allergies
[ ] Diabetes
[ ] High blood pressure
[ ] Problem with general anesthesia
[ ] Bleeding disorders (e.g., hemophilia)
[ ] Autoimmune disease

ALLERGIES TO MEDICATIONS

[ ] No allergies [ ] Latex Allergy [ ] Shellfish/Iodine Allergy [ ] Adverse reaction to Anesthesia

[ ] I am allergic to: _____

MEDICATIONS & SUPPLEMENTS

Do you take **blood thinners** (e.g., aspirin, warfarin/Coumadin, Plavix, etc.)? [ ] Yes [ ] No

Are you on **Oxygen**? [ ] Yes [ ] No

Please list all current prescription and over-the-counter medications/supplements:

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS | *Please check all that apply to you:*

[ ] History of Blood Transfusion
[ ] Did **NOT** have childhood Immunizations
[ ] Defibrillator
[ ] Pacemaker
[ ] Pregnant or Planning Pregnancy
[ ] Premedication prior to Procedures
[ ] Under Pain Management
[ ] Cough
[ ] Shortness of Breath
[ ] Wheeze
[ ] Dizziness
[ ] Headache
[ ] Double Vision
[ ] Increased Thirst
[ ] Dry Mouth
[ ] Dysphagia
[ ] Hearing loss
[ ] Sound Sensitivity
[ ] Hoarseness
[ ] Loss of Smell
[ ] Nasal Obstruction
[ ] Otalgia
[ ] Throat Pain
[ ] Heartburn
[ ] Increased Infections
[ ] Chest Pain
[ ] Dyspnea
[ ] Malaise
[ ] Bleeding
[ ] Bruising
[ ] New lesions
[ ] Rash
[ ] Skin, itching
[ ] Loss of Mobility
[ ] Musculoskeletal, pain
[ ] Neck Mass
[ ] Swelling
[ ] Hallucinations