EXHALE SINUS
TMJ | HEADACHE | SLEEP

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PATIENT REGISTRATION

PATIENT HEALTH HISTORY

PATIENT NAME: DATE OF BIRTH: AGE: HEIGHT: WEIGHT:

HOME PHONE: WORK PHONE: DO YOU HAVE A FEAR OF NEEDLES?: ☐ YES

RETAIL PHARMACY: PHONE: ADDRESS:

MAIL ORDER PHARMACY: PHONE:

REASONS FOR THIS VISIT: HOW DID YOU HEAR ABOUT US?:

PLEASE LIST THE NAMES OF ALL PHYSICIANS YOU CURRENTLY SEE (INCLUDE SPECIALTY AND CITY OF PRACTICE):

MEDICATIONS: (LIST ALL MEDICATIONS, INCLUDING DOSE AND HOW OFTEN YOU TAKE IT)

PLEASE LIST ALL **OVER THE COUNTER MEDICATIONS** (EXAMPLES: Tylenol, Advil) **HERBAL SUPPLEMENTS AND VITAMINS** YOU CURRENTLY TAKE.

ALLERGIES:

PREVIOUS MEDICAL HISTORY:
CHECK IF YOU OR ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING:

	MYSELF	FAMILY	RELATIONSHIP TO YOU
HIGH BLOOD PRESSURE	☐	☐	
HEART DISEASE	☐	☐	
STROKE	☐	☐	
DIABETES	☐	☐	
ASTHMA	☐	☐	
MALIGNANCY/CANCER	☐	☐	
BLEEDING TENDENCY	☐	☐	

DO YOU SMOKE/HOW OFTEN?

DO YOU USE ALCOHOL/HOW OFTEN?

REVIEW OF SYSTEMS:
CHECK IF YOU HAVE ANY OF THE FOLLOWING:

FATIGUE	☐ YES	☐ NO
VISION CHANGE	☐ YES	☐ NO
CHEST PAIN / PALPATIONS	☐ YES	☐ NO
SHORTNESS OF BREATH	☐ YES	☐ NO
DIGESTIVE PROBLEMS	☐ YES	☐ NO
URINARY DIFFICULTIES	☐ YES	☐ NO
MUSCLE OR JOINT PAINS	☐ YES	☐ NO
CHANGES IN SKIN	☐ YES	☐ NO
EASY BRUISING OR BLEEDING	☐ YES	☐ NO
UNINTENTIONAL WEIGHT LOSS OR GAIN	☐ YES	☐ NO
FEELINGS OF DEPRESSED MOOD	☐ YES	☐ NO
HEARING CHANGES	☐ YES	☐ NO

LIST ANY SURGERIES:

LIST OTHER ILLNESSES:

IS THERE A FAMILY HISTORY OF HEARING LOSS? ☐ YES ☐ NO

HAVE YOU EVER HAD AN AUDIOGRAM (HEARING TEST)? ☐ YES ☐ NO