

RANDALL F. HUMPHREYS, M.D.

PATIENT INFORMATION

Name: _____ Today's Date: ____/____/____

General Physician: _____ Referred: YES NO

CHIEF COMPLAINT-Reason for Visit.

1. _____

- ◆ Location (where) _____ ◆ Duration (how long) _____
- ◆ Quality (sharp/dull) _____ ◆ Timing (how often or when occurs) _____
- ◆ Severity Mild ◆ Moderate ◆ Severe ◆ Aggravates/Relieves (Context) _____
- ◆ Associated Signs _____ (Example: nausea, cough, congestion, rash, swelling)

Do you have/ or are you being treated for any of the following conditions:

- | | | |
|---------------------------------------------------|-------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Eyes(Dry Eye/Glaucoma) | <input type="checkbox"/> GERD(Reflux) | <input type="checkbox"/> Nervous System |
| <input type="checkbox"/> Ear, Nose, Mouth, Throat | <input type="checkbox"/> Other Stomach Problems | <input type="checkbox"/> Diabetes/Thyroid |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Tract | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Other Heart Problems | <input type="checkbox"/> Bones/Arthritis/Joints | |
| <input type="checkbox"/> Respiratory System | <input type="checkbox"/> Skin | <input type="checkbox"/> No Problems |

Any other problems not noted above: _____

Hospitalizations/Surgeries

Age or Date Admitted

_____	_____
_____	_____
_____	_____

Family History

Is there a **FAMILY** history of any of the following? (**Mother, Father, Siblings**)

	YES	NO	Relative		YES	NO	Relative
Asthma	___	___	_____	Eczema	___	___	_____
Hayfever	___	___	_____	Hives	___	___	_____
Nasal Polyps	___	___	_____	Immune Problems	___	___	_____

Do you smoke: No Yes How many packs a day? _____ How Many Years _____

Did you smoke in the past: No Yes How many packs a day? _____ For How Many Years _____

How Many Years Quit _____

Current Medications:

Dosage:

Times taken per day:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Drug Allergies / Intolerance's:

_____/_____/_____/_____ 2012