**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:***

| | | |
|---|---|---|
| ☐ Eyes(Dry Eye/Glaucoma) | ☐ GERD(Reflux) | ☐ Nervous System |
| ☐ Ear, Nose, Mouth, Throat | ☐ Other Stomach Problems | ☐ Diabetes/Thyroid |
| ☐ High Blood Pressure | ☐ Urinary Tract | ☐ Blood |
| ☐ Other Heart Problems | ☐ Bones/Arthritis/Joints | |
| ☐ Respiratory System | ☐ Skin | ☐ 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