NORTH FLORIDA SINUS CENTER
Part of North Florida Surgeons

6817 Southpoint Parkway, Suite 502
Jacksonville, FL 32216

Tel: 904-595-7475 Fax: 904-595-7480

Name: _____ **Date of birth**: _____ **Age**: _____

E-mail: _____ **Primary care physician full name**: _____

WHAT IS THE MAIN REASON FOR YOUR VISIT WITH US TODAY AS A NEW PATIENT? (CHIEF COMPLAINT/LIMIT TO 3)

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PAST MEDICAL HISTORY: (PLEASE CHECK ANY OF THE FOLLOWING CONDITION(S) WHICH AFFECT YOU CURRENTLY OR IN THE PAST)					
Migraine headaches		Heart Attack/Stent/Angina		Hearing loss/Ears ringing (tinnitus)	
Dizziness/Vertigo		Obstructive sleep apnea		Chronic ear infections/Ear drainage	
Diabetes Mellitus		High Blood Pressure		Depression/anxiety disorder	
Asthma/COPD/Emphysema		Stroke		Bleeding disorder/Current	
Prior skin cancer		Chronic Sinus Disease/Infections		History of cancer – type:	
Tuberculosis/ Hepatitis B or C/ HIV		IgA or IgM immunodeficiency		Other (please write below):	
Hyper or hypo-thyroidism		Autoimmune disorder (Lupus)			
GERD/Reflux		Rheumatoid Arthritis			

PAST SURGICAL HISTORY (LIST ANY PRIOR SURGERIES):

SOCIAL HISTORY:

DO YOU CURRENTLY SMOKE CIGARETTES OR CIGARS DAILY? YES/NO

MEDICATIONS: *(don't have to complete if already entered into Athena via iPad)*			
1		5	
2		6	
3		7	
4		8	

For office staff use: Date: _____ Initials: _____