NORTH FLORIDA SINUS CENTER
Part of North Florida Surgeons

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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):

	Surgery	Year		Surgery	Year
1.			4.		
2.			5.		
3.			6.		

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

Allergies:

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: _____