

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)

Prior history of migraines	Heart Attack/Stent/Angina	Diabetes Mellitus
Asthma/COPD	Obstructive sleep apnea	Chronic mastoiditis
HIV	Stroke	Depression/anxiety disorder
Hepatitis B or C	Chronic Sinusitis	Bleeding disorder
Hyper or hypothyroidism	IgA or IgM or IgG deficiency	History of cancer? (<i>Type and when/how treated</i>)
GERD/Reflux	Autoimmunity (Wegener's/Lupus/sarcoid)	
	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 in Athena via iPad*)

1		5	
2		6	
3		7	
4		8	

For office staff use:

Date: _____ Initials: _____