Oregon Health & Science University
Hospitals and Clinics
Department of Otolaryngology/
Head & Neck Surgery

NEW PATIENT HISTORY
OREGON SINUS CENTER

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Patient Age:_____

CLINICIAN NOTES ONLY

Please answer all of the following questions to the best of your ability.

Please write N/A if the question is NOT applicable to you.

CHIEF COMPLAINT:
What is the reason for this appointment?_____

HISTORY OF PRESENT ILLNESS:
Which of the following symptoms do you suffer?

☐ Nasal Obstruction ☐ Nasal discharge ☐ Headache ☐ Facial pressure/pain
☐ Decreased smell ☐ Bad breath ☐ Cough ☐ Fatigue

When did the problem(s) start?_____
Does anything make it better or worse?_____
Any other associated symptoms?_____
Have you been tested for allergies? ☐ Yes ☐ No When:_____ Results:_____

PAST MEDICAL HISTORY:

List the medicines you are taking:
1._____
2._____
3._____
4._____
5._____
6._____

List medical conditions you are/have been treated for (high blood pressure, diabetes, etc.)_____
_____
List previous surgeries:_____
_____
List drug allergies:_____
_____

Do YOU have any of the following:

NO	YES		NO	YES	
☐	☐	Asthma/Lung disease	☐	☐	Heartburn/Reflux
☐	☐	Arthritis	☐	☐	Kidney disease
☐	☐	Diabetes	☐	☐	Migraines
☐	☐	Excessive bleeding	☐	☐	Seizures
☐	☐	Fevers	☐	☐	Depression
☐	☐	Heart Disease	☐	☐	Stroke

If YES please describe:_____
_____

SOCIAL HISTORY:
Your occupation:
_____
Do you smoke/chew tobacco?
☐ Yes ☐ No How much:_____
Do you drink alcohol?
☐ Yes ☐ No How much:_____

FAMILY HISTORY:
Diseases that run in your family:
_____
_____

REFERRAL:
Who referred you to the office today?_____ Their address:_____

CLINICIAN USE ONLY: DR_____ HAS REVIEWED THE ABOVE INFORMATION WITH THE PATIENT DATE:_____

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