HARVARD MEDICAL SCHOOL MASSACHUSETTS EYE AND EAR INFIRMARY

SINUS CENTER MEDICAL INFORMATION FORM

PLEASE LIST YOUR PRIMARY CARE AND REFERRING DOCTORS NAME AND PHONE NUMBER:

_____

WHAT IS YOUR CURRENT PROBLEM? _____

WHAT TREATMENTS HAVE YOU TRIED? _____

Please answer the following questions:

Do you have any allergies(Medications, Latex, etc..)? _____

What are your current medications?

What are your current medical problems?

Have you had any surgeries(Please list month/year)?

Do you smoke? YES/NO Packs/day? _____ Have you ever smoked? YES/NO

Do you drink alcohol? YES/NO Drinks/week? _____

Have you experienced any of the following?

CONSTITUTIONAL	☐Fevers/Chills ☐Unintended Weight Loss ☐Other
EYES	☐Blurred Vision ☐Painful Eyes ☐Light Irritation ☐Other
EARS, NOSE, THROAT	☐Blocked Nose ☐Post Nasal Drip ☐Runny Nose ☐Other
CARDIOVASCULAR(HEART)	☐Palpitations ☐Chest Pain ☐Shortness of Breath ☐Other
RESPIRATORY(LUNGS)	☐Wheezing ☐Shortness of Breath ☐Cough ☐Other
GASTROINTESTINAL	☐Constipation ☐Diarrhea ☐Reflux ☐Other
GENITOURINARY	☐Urinary Hesitancy or Pain ☐Urination at Night ☐Other
MUSCULOSKELETAL	☐Soreness ☐Weakness ☐Cramping ☐Other
SKIN	☐Itching ☐Lesions ☐Rashes ☐Bleeding ☐Other
NEUROLOGICAL	☐Numbness ☐Weakness ☐Dizziness ☐Other
PSYCHIATRIC	☐Mood Swings ☐Anxiety ☐Depression ☐Stress ☐Other
ENDOCRINE	☐Hot Flashes ☐Hair Loss/Growth ☐Heat ☐Cold ☐Other
HEMATOLOGY	☐Night Sweats ☐Bleeding/Bruising ☐Clotting ☐Other