



HOLZER CLINIC

BP: _____ / _____ HEIGHT: _____
TEMP: _____ WEIGHT: _____
RESP: _____ O²/PULSE _____ / _____

NAME: _____

BIRTH DATE: _____

PLEASE LIST ALL AKA'S & MAIDEN NAME, (if applicable) _____

REASON FOR VISIT: _____

RECENT LABS / TESTS: _____

MEDICATION ALLERGIES: _____

PREFERRED PHARMACY: _____

ALLERGIC TO: LATEX, TAPE, IV DYE

CURRENT MEDICATIONS (INCLUDING VITAMINS & SUPPLEMENTS):

_____	_____
_____	_____
_____	_____
_____	_____

FAMILY DOCTOR: _____

REFERRING DOCTOR: _____

CHANGES IN ADDRESS, PHONE #, OR INSURANCE: YES / NO

EFFECTIVE 11/1/07 - ALL COPAYS ARE DUE BEFORE YOU SEE THE DOCTOR. PLEASE HAVE IT READY WHEN YOU RETURN THIS TO THE RECEPTIONIST. THANK YOU.

PAST OR CURRENT SYMPTOMS: (PLEASE CIRCLE ALL THAT APPLY):

HEAD/EYES: Headaches / Pressure
 Dizziness / Vertigo
 Blurry or Double Vision
 Itchy or Watery Eyes

EARS: Difficulty Hearing R / L / Both
 Ear Pain / Ear Fullness
 Pulling at ears (child)
 Noise in ears Popping / Ringing
 Ear Drainage

NOSE: Sinus Pressure / Pain
 Nasal Drainage
 Nosebleeds
 Snoring

THROAT: Hoarseness
 Sore Throat
 Choking Food / Pills
 Clearing Throat Often
 Difficulty Swallowing
 Lump in Neck / Throat
 Swelling or Fullness in Neck
 Fatigue

OTHER: _____

YOUR PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Cancer _____
Blood disorder _____
HIV / AIDS _____
Hepatitis _____
Ear infections _____
Depression / Anxiety _____

Diabetes _____
Asthma _____
Seizures _____
Sleep Apnea _____
Sinus infections _____
Kidney infections / disease _____

Heart Disease / Heart Murmur _____
Lung Disease _____
Stroke _____
High Blood Pressure _____
Glaucoma / Cataracts _____
Arthritis _____

Other _____

*Are you allergic to: LATEX TAPE IV DYE

PAST SURGICAL HISTORY (PLEASE CIRCLE AND DESCRIBE ALL THAT APPLY):

Ears / Tubes
Esophagus
Appendix
C-Section
Other:

Nose/Sinuses
Stomach/Intestines
Skin
Testicular/Prostate

Tonsils/Adenoids/Throat
Gallbladder
Hysterectomy
Thyroid- Total/Right/Left

PERSONAL / SOCIAL HISTORY:

Tobacco use? Yes / No If yes, how much? _____
Alcohol use? Yes / No If yes, how much? _____
Drug use? Yes / No Describe _____
Regular Exercise? Yes / No Days/week? _____
Quality of Sleep? Good Fair Poor

FAMILY HISTORY (PLEASE CIRCLE ALL THAT APPLY):

Heart Disease Diabetes Thyroid Disease
High Blood Pressure Stroke
High Cholesterol Cancer(other) _____
Blood Disorders (VonWillebrand's) (Hemophilia)

PLEASE LIST ANY OTHER MEDICAL INFORMATION THAT HAS NOT BEEN DESCRIBED ABOVE. THANK YOU FOR YOUR TIME AND EFFORT IN HELPING US OBTAIN A COMPLETE AND ACCURATE ACCOUNT OF YOUR MEDICAL HISTORY.

- DR. ROA AND STAFF
