Do not write, stamp, punch holes or affix a sticker in this area.

Patient History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a # 2 pencil

Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month | Day | Year

FIRST VISIT Mark all symptoms that pertain to you.

REPEAT VISIT Mark only the symptoms that you have experienced since your last visit.

Mark all that apply ---- if no symptoms, please mark "NONE."

General
chills ◯	weight loss ◯	night sweats ◯	
fever ◯	weight gain ◯	appetite loss ◯	
excessive perspiration ◯	feeling sick ◯	fatigue ◯	NONE ◯

Eyes
double vision ◯	"halos" around lights ◯	discharge ◯	
vision loss - 1 eye ◯	blurring ◯	eye irritation ◯	
vision loss – both ◯	light sensitivity ◯	eye pain ◯	NONE ◯

Ear, Nose, and Throat
	earache ◯	ringing in ears ◯	
ear discharge ◯	nosebleeds ◯	hoarseness ◯	
decreased hearing ◯	nasal congestion ◯	sore throat ◯	NONE ◯

Cardiovascular
		shortness of breath with exertion ◯	
swelling of hands or feet ◯	leg cramps with exertion ◯	bluish discoloration of lips or nails ◯	
chest pain or discomfort ◯	difficulty breathing lying down ◯	racing / skipping heartbeats ◯	NONE ◯

Respiratory
excessive sputum ◯	cough ◯	sleep disturbances due to breathing ◯	
wheezing ◯	excessive snoring ◯	coughing up blood ◯	NONE ◯

Gastrointestinal
	excessive appetite ◯	nausea ◯	
gas ◯	indigestion ◯	diarrhea ◯	
vomiting ◯	constipation ◯	difficulty swallowing ◯	
vomiting blood ◯	yellowish skin color ◯	dark tarry stools ◯	
abdominal pain ◯	change in bowel habits ◯	bloody stools ◯	NONE ◯

Genitourinary
painful urination ◯	trouble starting urinary stream ◯	pelvic pain ◯	
blood in urine ◯	inability to empty bladder ◯	genital sores ◯	
urinary urgency ◯	inability to control bladder ◯	missed periods ◯	
urinary frequency ◯	night time urination ◯	excessively heavy periods ◯	NONE ◯

Musculoskeletal
		muscle cramps ◯	
joint pain ◯	stiffness ◯	muscle weakness ◯	
joint swelling ◯	back pain ◯	muscle aches ◯	NONE ◯

Skin
		rash ◯	
itching ◯	suspicious lesions ◯	changes in color of skin ◯	
dryness ◯	poor wound healing ◯	changes in nail beds ◯	NONE ◯

Neurologic
headaches ◯	falling down ◯	tingling ◯	
poor balance ◯	fainting ◯	disturbances in coordination ◯	
numbness ◯	memory loss ◯	difficulty with concentration ◯	
tremors ◯	weakness ◯	sensation of room spinning ◯	NONE ◯

Psychiatric
	anxiety ◯	depression ◯	NONE ◯

Endocrine
	heat intolerance ◯	excessive thirst ◯	
cold intolerance ◯	excessive hunger ◯	excessive urination ◯	NONE ◯

Heme / Lymphatic
		abnormal bruising ◯	
bleeding ◯	skin discoloration ◯	enlarged lymph nodes ◯	NONE ◯

Allergic / Immunologic
persistent infections ◯	seasonal allergies ◯	HIV exposure ◯	NONE ◯

Licensed Under U.S. Patent Nos. 7,487,102 and 7,941,328 from Willis Technologies, LLC

Copyright © PatientLink Form 486 (Rev. 09/21/2017)
For technical support, please contact PatientLink at ***Support@MyPatientLink.com.***

Do not write, stamp, punch holes or affix a sticker in this area.

Patient History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

TOBACCO USE

What is your smoking status? current (every day) ○ current (some days) ○ previous ○ never ○

At what age did you begin smoking?

10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60 ○ 70 ○ 80 ○ 90 ○
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○

EXAMPLE
If you started at the age of 21, you would fill in the ovals like this:
10 ○ 20 ● 30 ○
1 ● 2 ○ 3 ○

If you quit smoking, at what age did you quit?

10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60 ○ 70 ○ 80 ○ 90 ○
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○

Do you use any of the following types of tobacco? chewing tobacco ○ pipes ○ cigars ○

How many packs per day do you (or did you) smoke? <1 ○ 1-2 ○ >2 ○

DRUG USE

none ○ current ○ previous ○ prefer to discuss with physician ○

ALCOHOL USE

How often do you use alcohol?

(Number of times...) never ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7+ ○

(Per...) week ○ month ○ year ○

YOUR MEDICAL HISTORY (patients 18 years or older)

Please indicate if YOU have a history of the following. (Mark all that apply. If none, mark, "NONE.")

allergy ○ | asthma ○ | autoimmune disease ○ | coagulopathy ○ | COPD ○
diabetes ○ | high blood pressure ○ | HIV-positive ○ | kidney disease ○ | liver disease ○
neurological disorder ○ | sleep apnea, obstructed ○ | stroke ○ | thyroid disease ○ | NONE ○

PEDIATRIC PATIENTS (0-17 years of age)

Does the PATIENT have a history of the following. (Mark all that apply. If none, mark, "NONE.")

developmental delay ○ | hyperbilirubinemia ○
NICU (neonatal intensive care unit) ○ | low birth weight ○ | newborn hearing screening failed ○
NONE ○

SURGICAL HISTORY

Please indicate if you have had any of the following surgeries.

nose surgery ○ | thyroidectomy ○ | tonsillectomy ○ | adenoidectomy ○ | ear surgery ○
myringotomy with tube placement ○ | parathyroidectomy ○ | heart surgery ○ | hysterectomy ○ | neck / spine surgery ○
splenectomy ○ | lung surgery ○ | carotid surgery ○ | brain surgery ○ | other ○ | **I HAVE HAD NO SURGERIES** ○

FAMILY MEDICAL HISTORY

Please indicate if YOUR FAMILY has a history of the following.
Include only parents, grandparents, siblings and children. Mark all that apply. If none, mark, "NONE."

anesthetic complications ○ | asthma ○ | bleeding disorders ○ | cancer ○
diabetes mellitus ○ | hearing loss ○ | heart disease ○ | hypertension ○
lung disease ○ | thyroid problems ○ | **FAMILY HISTORY UNKNOWN** ○ | NONE ○

Licensed Under U.S. Patent Nos. 7,487,102 and 7,941,328 from Willis Technologies, LLC

Copyright © PatientLink Form 486 (Rev. 09/21/2017)
For technical support, please contact PatientLink at ***Support@MyPatientLink.com.***