



SINU-CLEAR, INC., Office of Harvey D. Paley, M.D.

Welcome to our office! Please take the time to fill out this form as thoroughly as possible.

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

Referred By: _____

Primary Complaint: _____

How long have you had these symptoms? _____

Basic Medical History (Please check those that apply):

- High blood pressure
- Rheumatic fever
- Cancer
- Recent weight gain or loss
- Hepatitis/ jaundice/ kidney problems
- Epilepsy/ seizures/ fainting/ black- outs
- Respiratory problems/ asthma/ bronchitis
- Thyroid disorder
- Heart disease/ heart murmur/ angina/ irregular heartbeat
- Emphysema
- Blurred or double vision
- Heart attack
- GI/ Stomach problems/Ulcers
- HIV/ AIDS
- Diabetes
- Leukemia
- Shortness of breath
- Stroke
- Hay fever/ allergies
- Tuberculosis
- Reflux
- Migraines

Are you allergic to any medications? NO YES If yes, please list which medications you are allergic to: _____

Have you ever been tested for other allergies? ? No Yes

Have you ever had allergy shots? No Yes Was it helpful? No Yes

Are you currently using or have you ever used Afrin/Neosynepine Sudafed Benadryl

Cortisone or oral steroids such as Medrol Nasal saline irrigations/ Grossan irrigator

Claritin or Allegra

Please list any other medications and dosages including vitamins, herbs, or over the counter medications that you are currently taking or recently discontinued. Please include aspirin and ibuprofen: _____

Do you use recreational drugs? No Yes If yes, please list: _____

Do you use tobacco? If yes, how much? _____

Do you use alcohol? If yes, rarely, socially, frequently, or daily? _____

Do you drink caffeine? If yes, how much including coffee, tea, and soda? _____

Ear, Nose, and Throat History

Have you had your tonsils removed? No Yes ~ Date: _____

Have you had your adenoids removed? No Yes ~ Date: _____

Prior surgery for snoring or sleep apnea? No Yes ~ Date: _____

Prior nasal surgery? No Yes ~ Date: _____

Did your symptoms improve? No Yes ~ Drastic improvement / Little improvement/ No change

Have you ever been hospitalized for any other surgical procedure or serious illness? No Yes If yes, please give details dates: _____

- Sores/ lumps in or near your mouth
- Head, neck or jaw injuries
- TMJ
- Snoring
- Sleep Apnea
- Frequent sinus headaches
- Difficulty breathing through nose/Congestion
- Post nasal drip
- Runny nose
- Nasal Obstruction
- Hearing problems
- Dizziness
- Facial pain/Pressure
- Loss of sense of smell or taste
- Bad breath
- Sore throat
- Cough If yes, is it productive? Yes, I'm coughing up phlegm. No, it is a dry cough.
- Hoarseness/Laryngitis
- Frequent throat clearing
- Difficulty swallowing
- Recurrent sinus infections. If yes, please indicate number of infections in the past year: _____
- If applicable, please list all antibiotics you have taken in the past year: _____

Date last course of antibiotics was taken: _____

Did your symptoms improve after finishing the antibiotics? Yes No

Do you have difficulty falling asleep? Yes No

Have you ever been told by a partner that you have difficulty breathing in your sleep? Yes No

Have you ever fallen asleep while driving? Yes No While at school or work? Yes No

Have you ever had a CT Scan of your sinuses done? Yes No If yes, give date: _____

If you are coming in for a consult for the Sinu-Clear procedure, please bring the films with you.