MDVIP-AI

NEW PATIENT MEDICAL HISTORY FORM

Patient Name _____ **Date of Birth** _____

Record Medical # _____ **First Visit Date** _____

Instructions: Check each item that applies to you and use the line to provide additional information *for example: date, type, treatment, or other key details. Leave items unchecked if they do not apply.

Surgical History

Procedure / Surgical History	Additional Information
☐ Sinus surgery (Septoplasty, Balloon, other)	
☐ PE tubes (Ears)	
☐ Tonsils and/or adenoids	
☐ Abdominal procedures (Appy, Chole etc.)	
☐ GU (Female or Male) procedures	
☐ Cardiac (Bypass, stents valve replaced?)	
☐ Upper Endoscopy (EGD) findings	
☐ Lower Endoscopy (colonoscopy) findings	
☐ C-sections (Number)	
☐ Orthopedic surgery (Neck, Back, Joint etc.)	
☐ Other	
☐ Other	
☐ Other	
☐ Other	

Medical History

Diagnosis / Condition	Additional Information
☐ Angioedema (Skin swelling)	
☐ Allergic rhinitis (Hay fever)	
☐ Atopic Dermatitis / Contact Derm (ACD)	
☐ Asthma (Childhood, adult, both ?)	
☐ Arrhythmias (Abn. Heart beats)	
☐ Autoimmune Disease (RA, SLE, Sjogren's)	
☐ Anaphylaxis (life-threatening Allergy)	
☐ Anemia (B-12, iron deficient?)	
☐ Bronchitis (Treated with Inhaler?)	
☐ Cancer (Type, Diagnosis date, Treatment)	
☐ Celiac disease (Gluten intolerance)	
☐ Cholesterol elevation	
☐ Chronic fatigue (with fibromyalgia?)	
☐ COPD / Emphysema	

Medical History (continued)

Diagnosis / Condition	Additional Information
☐ Diabetes (Diet-controlled, Type 1, Type2)	
☐ Eosinophilic Esophagitis / Enteritis	
☐ Food Allergy (trigger and reaction)	
☐ GERD / LPR (Acid Reflux)	
☐ Glaucoma (one or both eyes)	
☐ Heart disease (Coronary artery, valvular)	
☐ Headaches (Migraine and Non-migraine)	
☐ Hypertension	
☐ Immune problems	
☐ Immunotherapy (allergy shots in past)	
☐ Insect sting allergy (Type?)	
☐ Irritable Bowel Syndrome (with D, C or both)	
☐ Lactose intolerance	
☐ Nasal polyps (R / L / Both sides)	
☐ Non-allergic rhinitis (irritant sensitivity)	
☐ Otitis media (recurrent)	
☐ Pneumonia (recurrent)	
☐ Prostate enlargement (BPH)	
☐ Psychiatric (ADD, Anxiety, Depression etc,)	
☐ Sinusitis (frequent)	
☐ Sinus Headaches	
☐ Sinus CAT scan (approx. last date/)	
☐ Sleep apnea (on C-PAP or other/)	
☐ Thyroid disease (Low or high/)	
☐ Urticaria (Hives)	
☐ Vertigo (Dizziness)	
☐ Vitamin D status (last testing?)	
☐ Vocal Cord Dysfunction	
☐ X-ray studies (Last Chest X-ray or CAT)	
☐ Other	
☐ Other	
☐ Other	
☐ Other	
☐ Other	
☐ Other	
☐ Other	
☐ Other	

Family History

Check conditions that apply to your family history. In the line, identify the family member as M (mother), F (father), or Sib (sibling), and add any other helpful information.

Medical Condition	Family Member (M / F / Sib) / Additional Information
☐ Allergic Rhinitis (Hay Fever)	
☐ Asthma (childhood or adult?)	
☐ Diabetes (Type1-Insulin requiring, Type 2?)	
☐ Coronary Artery Dz. (Heart attack, Bypass?)	
☐ Hypertension	
☐ Cancer (Types)	
☐ Autoimmune Dz. (Thyroid, RA, Lupus etc.)	
☐ Frequent infections	
☐ Food Allergies (including Celiac)	
☐ Other	
☐ Other	
☐ Other	

Social History

Social History Item	Response / Additional Information
Occupation setting (homemaker, Student, Job?)	
Common irritant or toxic exposures?	
Indoor animal exposures?	
Tobacco use (Average pack/day x years)	
Tobacco exposure (passive)?	
Current tobacco use?	
Past tobacco use (Quit date?)	
Alcohol use (Type and number per week)	
Drug use (Includes Marijuana)?	
Caffeine use daily (8 oz. or 100mg = one)	

Outdoor recreation? : _____

Other _____