

PATIENT'S NAME _____ DOB: _____

PLEASE USE BLACK INK ONLY

HEALTH MAINTENANCE:

If applicable, please provide most recent date (approximate month/year) and if test was normal or abnormal:

	Results		Results
Mammogram: _____	_____	Flexible Sigmoidoscopy: _____	_____
Colonoscopy: _____	_____	Pneumonia Vaccination: _____	_____

PAST MEDICAL HISTORY: (FOR PATIENT ONLY) Are you currently pregnant? ___ YES ___ NO

___ NONE	___ High Cholesterol	___ Otitis media
___ Allergies	___ Emphysema	___ Otosclerosis
___ Anemia	___ ENT Syndromes	___ Seizure disorder
___ Anxiety	___ GERD	___ Sleep apnea
___ Asthma	___ Headaches, migraines	___ Stroke
___ Birth trauma	___ Headaches	___ Tinnitus
___ Bleeding disorder	___ Hearing disorder	___ Vertigo
___ Cancer	___ High Blood Pressure	Other: _____
___ Chronic infection	___ Hyperthyroidism	Other: _____
___ Cleft lip	___ Hypothyroidism	Other: _____
___ Cleft palate	___ Micrognathia	Other: _____
___ Coronary artery disease	___ Microtia	Other: _____
___ Depression	___ Multinodular goiter	Other: _____
___ Diabetes	___ Obesity	Other: _____

SURGICAL HISTORY:

	NONE		
SURGERY	YEAR	YEAR	
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

FAMILY HISTORY: (For blood relative only; please list each family member below) ___ NONE

___ Allergies: _____	___ GERD: _____
___ Asthma: _____	___ Hearing disorder: _____
___ Autoimmune disease: _____	___ Hypertension: _____
___ Blood disorder: _____	___ Migraines: _____
___ Cancer: _____	___ Obesity: _____
___ Cardiovascular disease: _____	___ Kidney disease: _____
___ Chronic otitis media: _____	___ Seizure disorder: _____
___ Cleft lip/palate: _____	___ Sickle cell disease: _____
___ Coronary artery disease: _____	___ Sleep apnea: _____
___ Cleft palate: _____	___ Stroke: _____
___ Deafness: : _____	___ Thyroid disorder: _____
___ Depression: _____	Other _____
___ Developmental delay: _____	Other _____
___ Diabetes: _____	Other _____
___ High cholesterol: _____	Other _____

SOCIAL HISTORY:

TOBACCO USAGE: ___ Current ___ Former ___ Never ___ Unknown

Type: ___ Chewing ___ Cigar ___ Cigarettes ___ Pipe ___ Smokeless ___ Snuff

Units/day: ___ **# Years Used:** ___ **Ever tried to Quit:** ___ Yes ___ No **Year quit:** _____

Passive smoke exposure: ___ Yes ___ No

ALCOHOL USE: Drinks alcohol: ___ Yes ___ No ___ Formerly If formerly, year quit: _____

Type: ___ Beer ___ Liquor ___ Wine **Amount:** _____

Frequency: ___ Daily ___ Weekly ___ Monthly ___ Yearly ___ Occasionally ___ Rarely ___ Socially

RECREATIONAL DRUGS USAGE: ___ Current ___ Former ___ Never

STEROID DRUG USAGE: ___ Current ___ Former ___ Never

PATIENT'S NAME: _____ DOB: _____

HEIGHT: _____ **WEIGHT:** _____ **OCCUPATION:** _____

PREFERRED PHARMACY: _____

MEDICATIONS: _____ None _____ List attached

(Please make sure to include over-the-counter medications, vitamins and herbal remedies)

Name	Dose	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

ALLERGIES - Please list any allergies below (including allergies to latex or shellfish): _____ No known allergies

Name	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

REVIEW OF SYSTEMS: (Please check all that apply currently for the patient)

- | | | |
|--|--|---|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Visual changes | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Difficulty staying asleep |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Apnea during sleep | <input type="checkbox"/> Excessive daytime sleepiness |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Non-restorative sleep |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Snoring | <input type="checkbox"/> Numbness in extremities |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Choking on liquids | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Choking on solids | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Drooling | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Heartburn | |
| <input type="checkbox"/> Ear drainage | <input type="checkbox"/> Vomiting | OTHERS: |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Changes in urine color | _____ |
| <input type="checkbox"/> Mouth ulcers | <input type="checkbox"/> Difficulty with urination | _____ |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Urinary frequency | _____ |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Cold intolerance | _____ |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Heat intolerance | _____ |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Increased thirst | |

I have completed this medical history form and, to the best of my knowledge, it is complete and accurate. I understand that this document will be used for medical decision making and treatment. I hereby consent to treatment.

PATIENT SIGNATURE

DATE