Please indicate all past and present medical history and the dates of any surgical procedures if known.

Patient Name: ______________________________ Age: ________ Date of Birth: _____________

Reason for Visit: ______________________________

Preferred Pharmacy: ______________________________

Medication Allergies: ______________________________

PLEASE LIST All MEDICATIONS, INCLUDING OVER THE COUNTER DRUGS AND HERBS

Medications	Dosage	Purpose for taking the medication
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PERSONAL MEDICAL HISTORY

- ☐ Heart Disease
- ☐ Sleep Apnea
- ☐ Ear Problems
- ☐ Sinus Problems
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Heart Attack
- ☐ Cancer
- ☐ Asthma
- ☐ Kidney Disease
- ☐ Crohns Disease/ Ulcerative Colitis
- ☐ Seizure Disorder
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ COPD
- ☐ Emphysema
- ☐ Hearing Loss
- ☐ Spine Problems
- ☐ Seasonal Allergies
- ☐ Acid Reflux
- ☐ Meniere's Disease
- ☐ Other: _____________

SURGICAL HISTORY AND DATES

- ☐ Sinus Surgery
- ☐ Ear Tubes
- ☐ Parathyroid Surgery
- ☐ Mastoid Surgery
- ☐ Cardiac Bypass
- ☐ Carotid Endarterectomy
- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Thyroid Surgery
- ☐ Eardrum Repair
- ☐ Cardiac Angioplasty
- ☐ Heart Valve Replacement
- ☐ Joint repair
- ☐ Stomach surgery
- ☐ Anesthesia problems

☐ Other ______________________________

____

____

____

SOCIAL HISTORY

Tobacco Use:

- ☐ Never Smoked
- ☐ Smoker
- ☐ Current Every day Smoker
- ☐ Current Someday Smoker
- ☐ Former Smoker
- ☐ Current Status Unknown
- ☐ Unknown if ever smoked

Alcohol Use:

- ☐ Drinks/Day
- ☐ Non Drinker

Drug Use:

- ☐ Illicit Drug Use (type) ___________
- ☐ No Drug Use

ALL LABS AND TESTS (X-RAYS, MRI, CT, EKG ETC.)

TEST	DATE	REASON	ORDERING DR.
1.			
2.			
3.			
4.			
5.			

FAMILY MEDICAL HISTORY

RELATION	LIVING OR DECEASED	MEDICAL PROBLEMS, RECURRENT ILLNESSES…
Mother		
Maternal Grandmother		
Maternal Grandfather		
Father		
Father Paternal Grandmother		
Paternal Grandfather		
Sibling		
Sibling		
Sibling		