

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

- | | | |
|--|---|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> GERD | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches, migraines | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hearing disorder | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Birth trauma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hyperthyroidism | Other: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypothyroidism | Other: _____ |
| <input type="checkbox"/> Cleft lip | <input type="checkbox"/> Malignant Hyperthermia | Other: _____ |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Micrognathia | Other: _____ |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Microtia | Other: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Multinodular goiter | Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity | Other: _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Otitis media | |
| <input type="checkbox"/> ENT Syndromes | <input type="checkbox"/> Otosclerosis | |

SURGICAL HISTORY:

SURGERY	NONE	YEAR	YEAR
1. _____	<input type="checkbox"/>	_____	4. _____
2. _____	<input type="checkbox"/>	_____	5. _____
3. _____	<input type="checkbox"/>	_____	6. _____

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

- | | |
|---|--|
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Hearing disorder: _____ |
| <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Hearing disorder: _____ |
| <input type="checkbox"/> Autoimmune disease: _____ | <input type="checkbox"/> Hypertension: _____ |
| <input type="checkbox"/> Blood disorder: _____ | <input type="checkbox"/> Malignant Hyperthermia: _____ |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Migraines: _____ |
| <input type="checkbox"/> Cardiovascular disease: _____ | <input type="checkbox"/> Obesity: _____ |
| <input type="checkbox"/> Chronic otitis media: _____ | <input type="checkbox"/> Kidney disease: _____ |
| <input type="checkbox"/> Cleft lip/palate: _____ | <input type="checkbox"/> Seizure disorder: _____ |
| <input type="checkbox"/> Coronary artery disease: _____ | <input type="checkbox"/> Sickle cell disease: _____ |
| <input type="checkbox"/> Cleft palate: _____ | <input type="checkbox"/> Sleep apnea: _____ |
| <input type="checkbox"/> Deafness: : _____ | <input type="checkbox"/> Stroke: _____ |
| <input type="checkbox"/> Depression: _____ | <input type="checkbox"/> Thyroid disorder: _____ |
| <input type="checkbox"/> Developmental delay: _____ | Other _____ |
| <input type="checkbox"/> Diabetes: _____ | Other _____ |
| <input type="checkbox"/> GERD: _____ | Other _____ |
| <input type="checkbox"/> 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 Age 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 MEDICATION allergies below: _____ No known MEDICATION allergies
 _____ Shellfish/Contrast Dye/Iodine allergy
 _____ Latex allergy

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