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	____ GERD	____ Seizure disorder
____ Allergies	____ Headaches, migraines	____ Sleep apnea
____ Anemia	____ Headaches	____ Stroke
____Anxiety	____ Hearing disorder	____ Tinnitus
____ Asthma	____ High Blood Pressure	____ Vertigo
____ Birth trauma	____ High Cholesterol	____ **HIV/AIDS**
____ Bleeding disorder	____ Hyperthyroidism	Other:_____
____ Cancer	____ Hypothyroidism	Other:_____
____ Cleft lip	____ Malignant Hyperthermia	Other:_____
____ Cleft palate	____ Micrognathia	Other:_____
____ Coronary artery disease	____ Microtia	Other:_____
____ Depression	____ Multinodular goiter	Other:_____
____ Diabetes	____ Obesity	Other:_____
____ Emphysema	____ Otitis media	
____ ENT Syndromes	____ Otosclerosis	

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

SOCIAL HISTORY:

TOBACCO USAGE: ____ Current ____ Former ____ Never ____ Unknown

Type: ____Chewing/Snuff/Smokeless _____ Cigar ____ Cigarettes ____ Pipe ____ Vape

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)

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

OTHERS:
_____
_____
_____
_____
_____

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**