



# Patient History

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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: \_\_\_\_\_

## MEDICAL/SELF/FAMILY HISTORY

**\*List relationship to patient\***

<input type="checkbox"/> Heart Disease/Heart Attack _____	<input type="checkbox"/> Stroke/Vascular Disease _____	<input type="checkbox"/> Acid Reflux _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Meniere's Disease _____
<input type="checkbox"/> Cancer (indicate location) _____	<input type="checkbox"/> Thyroid Disease _____	<input type="checkbox"/> Hearing Loss _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> COPD/Emphysema _____	<input type="checkbox"/> Sleep Apnea _____
<input type="checkbox"/> Kidney Disease/Problems _____	<input type="checkbox"/> Seizure Disorder _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Stomach Ulcer _____	<input type="checkbox"/> Spine Problems _____	
<input type="checkbox"/> Bleeding Problems _____	<input type="checkbox"/> Seasonal Allergies _____	

## SURGICAL HISTORY and Dates

<input type="checkbox"/> Sinus Surgery _____	<input type="checkbox"/> Tonsil/Adenoid _____	<input type="checkbox"/> Stomach Surgery _____
<input type="checkbox"/> Ear Tubes _____	<input type="checkbox"/> Thyroid Surgery _____	<input type="checkbox"/> Anesthesia Problems _____
<input type="checkbox"/> Parathyroid Surgery _____	<input type="checkbox"/> Eardrum Repair _____	<input type="checkbox"/> Vocal Cord _____
<input type="checkbox"/> Mastoidectomy/Mastoids _____	<input type="checkbox"/> Cardiac Angioplasty _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cardiac Bypass _____	<input type="checkbox"/> Heart Valve Replacement _____	
<input type="checkbox"/> Carotid Endarterectomy _____	<input type="checkbox"/> Joint Replacement _____	

## SOCIAL HISTORY

Never Smoked  
 Smoker  
 Current Everyday 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

**\*\*PLEASE FILL OUT BOTH SIDES\*\***

**ALL LABS AND TESTS (X-rays, MRI, CT, EKG etc.)**

<b>TEST</b>	<b>DATE</b>	<b>REASON</b>	<b>ORDERING DR.</b>
1.			
2.			
3.			
4.			
5.			

**PLEASE LIST ALL MEDICATIONS, INCLUDING OVER THE COUNTER DRUGS AND HERBS**

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