

Patient Name: _____ Age: _____ Gender: M F

Past Medical History: Check all that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Immunologic |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> ulcers | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> hiatal hernia | <input type="checkbox"/> lupus |
| <input type="checkbox"/> heart failure | <input type="checkbox"/> gastric reflux | <input type="checkbox"/> immune deficiencies |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> Neurologic disorders | <input type="checkbox"/> Muscle/skeletal |
| <input type="checkbox"/> abnormal beat | <input type="checkbox"/> stroke | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> seizures | <input type="checkbox"/> gout |
| <input type="checkbox"/> asthma | <input type="checkbox"/> convulsions | <input type="checkbox"/> neck or back injury |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> low thyroid | <input type="checkbox"/> depression |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> high thyroid | <input type="checkbox"/> excessive anxiety |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> goiter | <input type="checkbox"/> Urologic |
| <input type="checkbox"/> frequent infections | <input type="checkbox"/> Allergy testing / shots | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> glaucoma | | <input type="checkbox"/> prostate enlargement |

Cancer (List type) _____

Other _____

Past Surgical History: Please check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Sinus surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Nose surgery | <input type="checkbox"/> Adenoidectomy |
| <input type="checkbox"/> Neck surgery | <input type="checkbox"/> Pressure equalizing tubes (ear tubes) |
| <input type="checkbox"/> Ear surgery | <input type="checkbox"/> Other _____ |

Medications: (List all medications you take regularly, prescription and over-the-counter)

Allergies: (drugs, food , insects, etc)

Family Medical History: (Check only if mother, father, siblings, or children have condition)

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Chronic ear disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Early hearing loss |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Anesthesia problems | |
| <input type="checkbox"/> Cancer(list type) _____ | | |
| <input type="checkbox"/> Other _____ | | |

Social History: (Check / fill in numbers where apply)

Alcohol Use: Never Several times a week
 Occasionally Daily

Tobacco Use: Use now Never used Quit (how long? _____)
Type: Cigarettes Cigars Chewing tobacco
Daily amount _____ Number years used _____

*****Has anyone in your immediate family ever been seen by a physician in this clinic?*

No _____ Yes _____ Name of family member seen: _____

Patient Signature _____ Date _____

Physician Signature: _____ Date _____