Last Name	First Name	Middle Initial

Preferred Name	Date of birth

PAST MEDICAL HISTORY

Medical	**Circle**		**Circle**
Alzheimer's/Dementia	Yes/No	Kidney stones	Yes/No
Asthma	Yes/No	Atrial fibrillation	Yes/No
Bipolar	Yes/No	Meningitis	Yes/No
Bronchitis	Yes/No	Myocardial infarction (heart attack)	Yes/No
Cancer/What Kind?_________________	Yes/No	Pacemaker/Defibrillator	Yes/No
Cerebrovascular accident (stroke)/TIA	Yes/No	Parkinson's disease	Yes/No
Cardiac murmur	Yes/No	Prostate Disease/ Surgery **Circle one**	Yes/No
Congestive heart failure	Yes/No	Pneumonia	Yes/No
Drug/Alcohol Addiction **Circle one**	Yes/No	Psoriasis/Eczema **Circle one**	Yes/No
Diabetes (Insulin or Non-Insulin) **Circle one**	Yes/No	Rheumatic fever	Yes/No
Ear infections	Yes/No	Schizophrenia	Yes/No
Emphysema/COPD	Yes/No	Seizure disorder	Yes/No
Hepatitis (A, B, or C) **Circle one**	Yes/No	Sexually transmitted disease_____________	Yes/No
Hypertension (high blood pressure)	Yes/No	HIV exposure	Yes/No
Hypothyroidism	Yes/No	Osteoporosis	Yes/No

Other____

SURGICAL HISTORY (EAR SURGERIES ONLY)

Procedure	Date performed	Performing Doctor
1.____	________________________	____________________
2.____	________________________	____________________

SURGICAL HISTORY (EXCLUDING EAR SURGERIES)

1.____	________________________	____________________
2.____	________________________	____________________
3.____	________________________	____________________
4.____	________________________	____________________
5.____	________________________	____________________
6.____	________________________	____________________
7.____	________________________	____________________
8.____	________________________	____________________

MEDICATION ALLERGIES

Drug

1.____
2.____
3.____
4.____
5.____

CT SCAN or MRI of head/brain (Circle one)

When: _________________
Where: ________________

Preferred Pharmacy: _________________________
Location: ___________________________________

ALL MEDICATIONS

Including over the counter	Dosage (mg)	How many per day
1.__________________________________	_________________	______________
2.__________________________________	_________________	______________
3.__________________________________	_________________	______________
4.__________________________________	_________________	______________
5.__________________________________	_________________	______________
6.__________________________________	_________________	______________
7.__________________________________	_________________	______________
8.__________________________________	_________________	______________
9.__________________________________	_________________	______________

FAMILY MEDICAL HISTORY (e.g. father, mother, siblings, grandparents, aunts, uncles, etc.) **(Circle one)**

Hearing loss Yes/No Who: ____________________
Cancer Yes/No What kind?____________Who: ____________
Diabetes Yes/No Who: ____________Insulin/Non insulin dependent/Gestational:(**circle one**)
Heart disease Yes/No Who: ____________________

SOCIAL HISTORY **(Circle one)**

Tobacco Currently Smoke Former Smoker Never Smoked

Alcohol Occasional Moderate Heavy None

Marital Status Married Single Divorced Widowed

Caffeine Yes/No How Much_______/day

Occupation: ____________________ Retired Occupation: ____________________

If patient is a child: **(Circle one)**

Daycare Currently Used Yes/No
School Grade: _________
If Premature/How many weeks? _______________

CURRENT health complaints only

EARS, NOSE, MOUTH & THROAT **Circle**

Difficulty hearing Yes/No
Ear pain Yes/No
Ear drainage Yes/No
Ringing in the ears Yes/No
Nasal congestion Yes/No

ALLERGIES

Seasonal allergies (Spring, fall, summer) Yes/No
Frequent colds Yes/No

EYES

Glaucoma Yes/No
Visual Disturbances Yes/No
Glasses/ Contacts Yes/No

INTEGUMENTARY

New lesions Yes/No
Change in wart/mole Yes/No
Itching Yes/No
Rash Yes/No

RESPIRATORY

Chronic cough Yes/No
Wheezing Yes/No
Difficulty breathing Yes/No

CARDIOVASCULAR

Chest pain Yes/No
Irregular heart beat Yes/No
Palpitations Yes/No
Swelling of the extremities Yes/No

GASTROINTESTINAL

Food intolerance Yes/No
Heartburn Yes/No
Difficulty swallowing Yes/No
Abdominal pain Yes/No
Constipation Yes/No
Diarrhea Yes/No

GENITOURINARY

Urinary frequency/urgency Yes/No
Testicular/pelvic pain **circle one** Yes/No
Menstrual Irregularities Yes/No

MUSCULOSKELETAL

Muscle pain Yes/No
Muscle cramps Yes/No
Muscle weakness Yes/No
Joint pain Yes/No

NEUROLOGICAL

Dizziness/Vertigo Yes/No
Headaches Yes/No
Seizures Yes/No
Tremors Yes/No

PSYCHIATRIC

Anxiety Yes/No
Depression Yes/No
Mood changes Yes/No
Change in sleep patterns Yes/No

ENDOCRINE

Excessive thirst Yes/No
Excessive urination Yes/No
Thyroid problem Yes/No

HEMATOLOGIC/LYMPHATIC

Bleeding problems Yes/No
Anemia Yes/No
Enlarged lymph nodes Yes/No

VITALS

Height __________ft__________in
Weight__________lbs__________oz

VACCINATIONS

Pneumococcal Vaccine Yes/No
(pneumonia) If yes When?__________