

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

(Include Pharmacy Name, Phone Number, and Zip code)

■ **NATURE OF VISIT:**

~ Chief Complaint (Reason for today's visit): \_\_\_\_\_

Do you currently take ANY medications:  Yes  No If Yes, list Name of Medication, Dosage and Frequency:

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Drug Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, list Name of Drug and Reaction:	
Name of Drug		Reaction	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
Latex Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No			

■ **PAST MEDICAL HISTORY** (Have you been diagnosed with any of the following? Please check all that apply.)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Head Injury          | <input type="checkbox"/> Sleep Apnea          |
| <input type="checkbox"/> Aneurysm            | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Hearing Loss   | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Thyroid Disorder     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Hypertension/High BP | <input type="checkbox"/> Tinnitus             |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> GERD/Reflux    | <input type="checkbox"/> Mental Disorder      | <input type="checkbox"/> Vitamin D Deficiency |
| <input type="checkbox"/> Cancer; Type: _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Migraines            |   |
| <input type="checkbox"/> Glaucoma/Cataracts  | <input type="checkbox"/> Lung Disease   | <input type="checkbox"/> Pacemaker            |   |
| <input type="checkbox"/> Other: _____        |   |   |   |

■ **PAST SURGICAL HISTORY**

- |  |  |
|--|--|
| ○ <b>ENT Surgery(ies)</b>              | ○ <b>Other Surgery(ies)</b>            |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Nasal/Sinus   |
| <input type="checkbox"/> Ear Surgery   | <input type="checkbox"/> Thyroid       |
| <input type="checkbox"/> Ear Tubes     | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Other: _____  | _____                                  |
|  | _____                                  |
|  | _____                                  |

■ **FAMILY HISTORY** (Do any family members have any of the medical problems listed below?)

- |   | Relationship |  | Relationship |
|---|--------------|--|--------------|
| <input type="checkbox"/> Asthma             | _____        | <input type="checkbox"/> Heart Disease       | _____        |
| <input type="checkbox"/> Bleeding Disorders | _____        | <input type="checkbox"/> High Blood Pressure | _____        |
| <input type="checkbox"/> Cancer             | _____        | <input type="checkbox"/> Kidney Disease      | _____        |
| <input type="checkbox"/> Diabetes           | _____        | <input type="checkbox"/> Liver Disease       | _____        |
| <input type="checkbox"/> Hearing Loss       | _____        | <input type="checkbox"/> Stroke              | _____        |

■ **SOCIAL HISTORY**

Do you use Tobacco? (cigarettes,vape,cigars,pipe,snuff/chew)  Yes  No

o If Yes please indicate TYPE and Frequency: \_\_\_\_\_

If you quit using tobacco please list the year you quit: \_\_\_\_\_ How many years did you use tobacco? \_\_\_\_\_

Do you use alcohol?  Yes  No If yes please indicate frequency: \_\_\_\_\_

If you quit using alcohol please list the year you quit: \_\_\_\_\_ How many years did you drink? \_\_\_\_\_

■ **PATIENTS 65 AND OVER**

Do you have a living will or advanced directive?  Yes  No

<p>X</p> <p>_____</p> <p><b>PATIENT or RESPONSIBLE PARTY SIGNATURE</b></p> <p>In Lieu of Signature Option, if not available, please type name and initial.</p>	<p>_____</p> <p><b>TODAY'S DATE</b></p>
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