

Patient Medical History

Name: _____ Age: _____ Date: _____

Reason for appointment: _____

Accident related? Give date and details of accident: _____

Primary Pharmacy Name and Number: _____

Referring Doctor (if there is no referring doctor list how you found our office) _____

◆ Are you **allergic** to any **medications**? Y / N If yes, please list medications and reaction: _____

◆ Do you have environmental allergies? No ____ Yes ____ Have you been tested for allergies? No ____ Yes ____

◆ Do you have food sensitivities? No ____ Yes ____ Which foods? _____

◆ Are you currently on allergy shots or have you ever been on allergy shots? Y / N _____

◆ Do you take any **medications**? Y / N If yes, please list: _____

◆ Have you had any **previous surgery**? Y / N If yes, please list: _____

Do you **smoke**? Y / N If yes how many ppd? _____ How many years total? _____

Have you **ever smoked**? Y / N When did you quit? _____ How long did you smoke? _____

Do you use **other tobacco products**? Y / N What Type? _____ How Much? _____

Do you **drink alcohol**? Y / N Number per day _____ Number per week _____ Number per month _____

Have you **ever drank alcohol**? Y / N Number per day _____ Number per week _____ Quit _____

Do you use or have your ever used **recreational drugs**? Y / N

Which drugs have you used in the past and when is the last time you have used? _____

Please check the ones that apply to you and your family.

Medical Conditions	Yourselves NO	Yourselves YES	Family YES	Explanation Specify family member if you marked Yes
Heart Disease/ Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease/ Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver/Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please check the current symptoms you are experiencing.

<input type="checkbox"/> Ear Pain/ Ear Drainage	<input type="checkbox"/> Nasal Congestion/ Drainage	<input type="checkbox"/> Weight Loss/ Fatigue
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Facial Pain/ Sinus Pain	<input type="checkbox"/> Sore throat/ Cough
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Problems Swallowing	<input type="checkbox"/> Muscle or Joint Pain
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/> Heartburn/ Indigestion	<input type="checkbox"/> Skin Lesion or Rash
<input type="checkbox"/> Headache	<input type="checkbox"/> Head or neck swelling	<input type="checkbox"/> Snoring/ Mouth Breathing
<input type="checkbox"/> Numbness/ Weakness	<input type="checkbox"/> Lumps or nodules	<input type="checkbox"/> Stuffy/ Runny Nose
<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Fever	<input type="checkbox"/> Other

If other please specify: _____

Present Occupation: _____

I certify that the above information is complete and accurate.

Patient's Signature: _____ **Date:** _____

I certify that I have reviewed the above information with the patient.

Physician's Signature: _____ **Date:** _____