

Account # \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pharmacy Name & Location: \_\_\_\_\_

Brief reason for today's visit:

\_\_\_\_\_  
\_\_\_\_\_

Please list Allergies to medications:  None

\_\_\_\_\_  
\_\_\_\_\_

List any tests performed related to your condition  
(e.g. blood work, ultrasound, CT scan, or MRI):

\_\_\_\_\_  
\_\_\_\_\_

Allergy to latex:  Yes  No

Allergy to tape:  Yes  No

Allergy to iodine/IV dye:  Yes  No

**Personal Health History**

Heart Disease (heart attack, stents, etc)

Stroke

High Blood Pressure

Diabetes

Asthma/Emphysema/COPD

Hepatitis

HIV+

Anesthesia problems

List other medical problems (even if they are under control):  None

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List all surgeries you have had & approximate dates  
(Please include non-Ear/Nose/Throat surgeries):  None

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Family History**

(Parents, children, siblings, grandparents)

Thyroid cancer

Otitis media (ear infections)

Hearing loss

List all medications, herbs or other supplements you presently take, and their dosage:  None

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you now, or have you ever used:

1. Tobacco?  Current  Former  Never

If yes, how many packs per day? \_\_\_\_\_

Year Started \_\_\_\_\_ Year Quit \_\_\_\_\_

2. Alcohol?  Current  Former  Never

If yes, how many drinks per week? \_\_\_\_\_

Do you have a heart murmur?  Y  N

Do you take any blood thinners?  Y  N

Do you have a pacemaker?  Y  N

Have you had hip/knee/joint replacement?  Y  N

Do you need to take an antibiotic before routine dental work?  Y  N

Do you or any member of your family have malignant hyperthermia or other problem with anesthesia?  Y  N

Additional pertinent information:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_