PATIENT MEDICAL QUESTIONNAIRE/HISTORY

Patient Name: _____ Appt Date: _____

Current height: _____ Current weight: _____

Primary care physician: _____ Phone #: _____

Were you referred to us by your doctor: YES NO

If yes, please give the doctor's name & location: _____

Pharmacy Name & Phone number: (specify location) _____

Prescriptions will be sent electronically to your pharmacy, please let us know if you need

MEDICATIONS & ALLERGIES

Are you taking any prescribed or over-the-counter medications? YES NO

Medication Name	Dosage Frequency	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any blood thinners? YES NO _____

Do you have any allergies? YES NO

Medication & Reaction	Medication & Reaction
_____	_____

Are you pregnant or planning to become pregnant? YES NO N/A

PAST MEDICAL HISTORY: Have you been diagnosed with any of the following? (circle all that apply)

Reflux/GERD	Seasonal allergies	Neurological issues	Migraines
Hernia	Hearing loss	High cholesterol	Psychiatric disorder
Dizziness	High blood pressure	Autoimmune disease	Kidney disease
Asthma	Stomach/bladder issues	Glaucoma/Cataracts	Sleep apnea
TIA/Stroke	Bleeding disorder	Diabetes	COPD
Neuropathy	Cancer	NONE	

Any other: _____

INITIALS_____

PATIENT MEDICAL QUESTIONNAIRE/HISTORY

PAST SURGICAL HISTORY Have you ever had surgery, check all that apply and approximate date

Tonsillectomy/adenoidectomy	Laryngeal/voice box surgery	Thyroid surgery
Septoplasty	Ear tubes	Sinus surgery
Tympanoplasty	Neck surgery	Mastoidectomy
Other: _____	**Surgery & Date**	**Surgery & Date**
None	_____	_____

SOCIAL HISTORY

Do you smoke? YES NO How many cigarettes/packs per day _____

Are you regularly exposed to second hand smoke? YES NO

Do you use any nicotine replacement system? YES NO

Do you chew tobacco? YES NO

Do you drink alcohol? YES NO If so, how much? _____

Do you use illegal substances? YES NO If so, how much? _____

FAMILY HISTORY Have any family members been diagnosed with any of the following? Circle all that Apply? NONE

Relationship	Relationship
Hearing loss _____	Diabetes _____
Cancer _____	Autoimmune _____
Heart disease _____	Bleeding disorder_____

Other (please list): _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____