**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

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

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

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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