PATIENT MEDICAL HISTORY FORM

Patient's Last Name: _____ **M .I.**____ **First**_____ **Date Of Birth** ____/___/_____

Sex Assigned at Birth: MALE | FEMALE **Pronouns:** _____ **Height** _____ ft _____ in **Weight** _____lbs

Reason for Visit _____

Latex Allergy: YES | NO **Adhesive Allergy:** YES | NO **Contrast Dye:** YES | NO **Medication Allergies:** YES (please list below) | NO

Allergies to Medications: _____

CURRENT MEDICATIONS - Please list below

DRUG NAME	4	8
1	5	9
2	6	10
3	7	11

EAR

- ○ Ache / Pain
- ○ Drainage
- ○ Ear Fullness
- ○ Hearing Loss - **R** or **L**
- ○ Itching
- ○ Ringing

NASAL / SINUS

- ○ Allergies
- ○ Altered Smell
- ○ Congestion
- ○ Deviated Septum
- ○ Facial Pain
- ○ Nasal Polyps
- ○ Nosebleeds (Epistaxis)
- ○ Post Nasal Drip
- ○ Runny Nose
- ○ Sinus Headaches
- ○ Sinus Infections

ENDOCRINE

- ○ Thyroid Disease
- ○ Thyroid Enlargement
- ○ Diabetes
  - ○ Type 1
  - ○ Type 2
- ○ Kidney Disease

ORAL / THROAT

- ○ Trouble Swallowing
- ○ Reflux
- ○ Hoarseness
- ○ Altered Taste
- ○ Tonsillitis
- ○ Mouth Ulcers
- ○ Dry Mouth
- ○ Sore Throat

RESPIRATORY

- ○ Cough
- ○ Snoring
- ○ Sleep Apnea
- ○ Asthma
- ○ Wheezing
- ○ Bronchitis
- ○ COPD
- ○ Pneumonia
- ○ Tuberculosis

CANCER

Type:_____

_____

_____

Location: _____

_____

_____

CARDIAC

- ○ A-fib
- ○ Hypertension
- ○ High Cholesterol
- ○ Irregular Heartbeat
- ○ Heart Murmur
- ○ CAD
- ○ Chest Pain
- ○ Heart Attack
- ○ High Heart Rate
- ○ Slow Heart Rate
- ○ Syncope
- ○ Pacemaker

NEUROLOGIC

- ○ Headache
- ○ Migraine
- ○ Numbness
- ○ Dizziness
- ○ Vertigo
- ○ Stroke / TIA
- ○ Seizures
- ○ Epilepsy
- ○ Developmental

IMPLANTS

- ○ Irremovable Implanted Metal

GASTROINTESTINAL

- ○ Hepatitis
- ○ Liver Disease
- ○ Hiatal Hernia

PSYCHIATRIC

- ○ Anxiety
- ○ Depression
- ○ Bipolar Disorder
- ○ Schizophrenia
- ○ Suicidal Thoughts
  - ○ Past
  - ○ Current

CONGENITAL DISORDERS

- ○ Downs Syndrome
- ○ Autism

BLOOD BORNE DISEASES

- ○ Hepatitis B
- ○ Hepatitis C
- ○ HIV

OTHER MEDICAL HISTORY

- ○ Malignant Hyperthermia

HEMATOLOGIC

- ○ Bleeding / Clotting Tendency or Disorder

IF PATIENT IS UNDER 18:

Born on time: YES | NO

Does anyone in the household smoke? YES | NO

Does child attend daycare or preschool? YES | NO **How many days?** _____

School Grade Child - Grade: _____

PARENTAL INVOLVEMENT

Both parents are involved: YES | NO or **Single Parent Family:** YES | NO

If join custody, the child primarily lives with _____ **or** 50/50

SURGICAL HISTORY	YEAR

SOCIAL HISTORY

EMPLOYED: YES | NO **OCCUPATION:** _____ **RETIRED:** YES | NO **DISABLED:** YES | NO

SUBSTANCE USE - Please indicate current or past use.

Caffeine: YES | NO **CURRENT or PAST**

Tobacco: YES | NO **CURRENT or PAST** | **HOW LONG (YEARS):** _____ **YEAR STOPPED:** _____

Alcohol Use: YES | NO **CURRENT or PAST** | **HOW LONG (YEARS):** _____ **YEAR STOPPED:** _____

Street Drugs: YES | NO **CURRENT or PAST** | **HOW LONG (YEARS):** _____ **YEAR STOPPED:** _____

DRUG TYPE: _____

If family history is unknown please indicate why: Unknown: _____ **Adopted:** _____ **Prefer not to say:** _____

FAMILY HISTORY	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER	DESCRIPTON
CANCER							
HEART DISEASE							
DIABETES							
STROKE							
HIGH BLOOD PRESSURE							
HIGH CHOLESTEROL							
ANESTHESIA COMPLICATION							
HEARING LOSS							
BLEEDING DISORDER							
SLEEP APNEA							
ALLERGIES							
OTHER							

Print Name_____ **Sign**_____ **Date** _____/_____/_____