PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for you doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Social Security Number (SSN) _____ Date of Visit_____

Full Name_____ Date of Birth_____ Age_____

Pharmacy Preference (include location) _____

Name of Primary Care (Family)
Physician_____Address_____

(Current Medications)
Are you taking ANY kind of medication now? (This includes prescription, over-the-counter, or herbal medications)□ No □ Yes
If yes, please list below *include dosages*.

Medication Name	Dosage	How often taken

(Medication Allergies) **ARE YOU ALLERGIC TO ANY MEDICATIONS?** □ No □ Yes If yes, please list below.

Name of Medication	Type of Reaction

(Non-Medication Allergies) Are you allergic to anything in the environment such as grass, dust, food, etc.?
□ No □ Yes If yes, please indicate what you are allergic to._____
Have you ever had an allergy test? □ No □ Yes
(Past Health History) Have you ever been ***DIAGNOSED*** with any of the following problems?

Cancer (type)_____□ No □ Yes
Nose and Sinus:
Nasal Allergies □ No □ Yes
Heart and Blood Vessels:
High/Elevated Cholesterol □ No □ Yes
High Blood Pressure □ No □ Yes
Lungs and Respiratory:
Tuberculosis □ No □ Yes
Stomach and Digestive:
Duodenal ulcer □ No □ Yes
Hepatitis □ No □ Yes
Stomach ulcer □ No □ Yes
Genitourinary:
Renal failure □ No □ Yes

Are you pregnant? □ No □ Yes
Mental & Emotional:
Anxiety □ No □ Yes
Depression □ No □ Yes
Glands, Hormones, and Sugar Control:
Diabetes □ No □ Yes
Thyroid deficiency □ No □ Yes
Thyroid excess □ No □ Yes
Blood & Lymph Node Problems:
Anemia □ No □ Yes
Allergies, Immune & Infectious:
HIV □ No □ Yes
Infectious Mononucleosis □ No □ Yes

If you have any other medical problems that we have not covered above, please list those here:_____
_____

(Surgeries and Hospitalizations)
Have you ever had any problems with anesthesia (being numbed or put to sleep)? □ No □ Yes
If yes, please list what sort of problems. _____
Have you ever had ear, nose or throat surgery? □ No □ Yes
If yes, list any surgeries and when they were done. _____
Have you been hospitalized for a medical problem before? □ No □ Yes
If yes, list hospitalizations, the reason for admission and the date. _____

TURN OVER PLEASE!

(Family History)

Specific Anesthesia Problem □Mother □Father □Brother □Sister

Cancer:

Lung Cancer □Mother □Father □Brother □Sister

Ears:

Hearing Loss before 20 □Mother □Father □Brother □Sister

Hearing Loss after 20 □Mother □Father □Brother □Sister

Nose and Sinus:

Nasal Allergies □Mother □Father □Brother □Sister

Heart and Blood Vessels:

Heart Disease □Mother □Father □Brother □Sister

Hypertension □Mother □Father □Brother □Sister

Lungs and Respiratory:

Asthma □Mother □Father □Brother □Sister

Brain and Nervous:

Stroke □Mother □Father □Brother □Sister

Blood & Lymph Node Problems:

Bleeding/clotting problem □Mother □Father □Brother □Sister

Other_____□Mother □Father □Brother □Sister

(Social History)

What is or was your occupation?_____□ Check here if you're retired.

Have you ever used tobacco in any form? □ No □ Yes

If yes, please complete the following:

Do you consume alcohol? □ No □ Yes

If yes, please complete the following:

Type of Tobacco	From	To Year	Type of Alcohol	How Much	How Often
Cigarettes per day:_____					
Other: (list type)					

Do you use drugs recreationally? □ No □ Yes If yes, please list_____

Are you exposed to second hand smoke? □ No □ Yes

(Review of Systems): Mark yes or no and CHECK any of the following you have recently had.

Constitutional Symptoms □ No □ Yes

□fever, □sleeping problems, □unintentional weight loss

Eye problems □ No □ Yes

□double vision, □itchy eyes

Ears, Nose, Mouth and Throat problems □ No □ Yes

□dizziness, □ear drainage, □hearing loss, □ear pain, □ringing, □chronic congestion, □post-nasal drainage, □hoarseness/change in voice, □snoring, □sore throat, □ulcers

Cardiovascular □ No □ Yes

□blacking out or fainting, □bluish discoloration of lips or fingernails, □chest pain, □irregular heartbeat, □leg cramps, □swelling of ankles

Respiratory problems □ No □ Yes

□freq non-productive cough, □freq productive cough □shortness of breath, □wheezing

Gastrointestinal problems □ No □ Yes

□abdominal pain, □diarrhea, □heartburn, □nausea, □vomiting

Musculoskeletal problems □ No □ Yes

□neck pain

Neurological problems □ No □ Yes

□headache, □numbness, □severe facial pain, □seizures, □weakness

Problems with Endocrine □ No □ Yes

□appetite increased, □increased fatigue, □feels hot when others do not, □feel cold all the time, □neck has enlarged, □unwanted weight change

Problems with Hematological/Lymphatic □ No □ Yes

□bleeds excessively after injury, □bruises easily, □neck masses or lumps

Allergic, Infectious, Immunologic problems □ No □ Yes

□food intolerances, □hives, □severe reaction to insect bites, □frequent sneezing

What is the main reason you are seeing the doctor today?