NAME:____ DOB:_______________ DATE: _____________

PAST MEDICAL HISTORY (circle all that apply)

Alcoholism Allergy Testing Allergy to (circle all that apply) eggs/milk products/peanuts/pet hair or dander/seafood

Anxiety Asthma Atrial fibrillation Auditory processing disorder Bleeding disorders Bronchitis Cancer Cervicalgia

Chronic sinusitis Colitis Congestive heart failure COPD Diabetes Emphysema Graves' disease Heart attack

Heart disease Heartburn Hepatitis High blood pressure History of Tobacco use HIV/AIDS Hypothyroid

Impacted cerumen Irritable bowel syndrome High cholesterol Obstructive sleep apnea Peripheral vascular disease

Pharyngitis Pneumonia Stroke Thyroid cancer Tuberculosis Vertigo

CIRCLE CHRONIC PROBLEMS

Respiratory: Shortness of breath, chronic or bloody cough, wheezing

Cardiovascular: Shortness of breath on exertion, chest pain, palpitations

Gastrointestinal: Nausea, vomiting, diarrhea, constipation

Genitourinary: Frequent urination, pain or burning on urination, urinary infection

Neurological: Seizures, convulsions, weakness, numbness

Psychiatric: Stress, depression, substance abuse

PAST SURGICAL HISTORY (circle all that apply)

Adenoidectomy Ear surgery (other than tubes) Esophagus surgery Facial cosmetic surgery Heart surgery Lung surgery Ear Tubes
Nose surgery Sinus surgery Thyroid surgery Tonsillectomy Appendectomy Hysterectomy Cholecystectomy Back surgery Joint replacement

Other: ____

FAMILY HISTORY Does /did the patient's mother (M), father (F), brother (B), sister (S) have/had any of the following illnesses or problems? Please circle.

Heart attack	NO	YES	M	F	B	S
Diabetes	NO	YES	M	F	B	S
High blood pressure	NO	YES	M	F	B	S
Tuberculosis	NO	YES	M	F	B	S
Cancer	NO	YES	M	F	B	S
Bleeding Disorders	NO	YES	M	F	B	S

MEDICATION (Please list any **medications** and **doses** you are currently taking including vitamins, supplements, over the counter medications.)

____

____

MEDICATION ALLERGIES (Please list allergy and reaction, e.g. rash, hives, swelling)

____

SOCIAL HISTORY

Have you ever smoked? CURRENTLY PREVIOUSLY NEVER How many packs/day? ___________ How many years? _______
Have you ever used chewing tobacco? YES NO How many packs/tins per day? _______________
Have you ever used recreational drugs? YES NO
Do you drink alcohol? YES NO How many drinks/week? ___________
Occupation (prior to retirement if you are retired) _________________________________
Have you ever had a blood transfusion? YES NO
Are you up to date on immunizations? YES NO
When was your last pneumonia vaccination? ______________________ flu vaccination? ______________________