PATIENT HEALTH HISTORY

Please complete both pages.

We need to obtain your complete medical history, so it is important for you to fill out this form as completely as possible. This is very important information. **Please complete every item.** Your doctor needs to know that you have carefully reviewed every area of this form. This information will be entered into your medical record.

Full Name________________________ ☐ **Male** ☐ **Female** **Date of Birth** ___________

Pharmacy Preference (include location) ________________________________

Primary Care Physician ____________________ **Referring Physician** ____________________

Reason for visit ________________________________ **Date of Visit** ___________

Height: ________ **Weight:** ________ **Fecal Occult Blood Testing:** ☐ No ☐ Yes **Month:**_____ **Year:** ______

Flu Vaccine: ☐ No ☐ Yes **Month:**_____ **Year:** ______ **Pneumonia Vaccine:** ☐ No ☐ Yes **Month:**______ **Year:** ______

Sigmoidoscopy: ☐ No ☐ Yes **Month:**______ **Year:** ______ **Colonoscopy:** ☐ No ☐ Yes **Month:**______ **Year:** ______

Current Medications

Are you taking ANY kind of medication now? ☐ No ☐ Yes If yes, please list below *including dosages*.
(This includes prescription, over-the-counter medicines including nasal sprays, or herbal medications)

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: ________________________________

Do you have an allergy to LATEX? ☐ No ☐ Yes 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 Problems:

HIV ☐ **No** ☐ **Yes**

Infectious mononucleosis ☐ **No** ☐ **Yes**

Surgeries and Hospitalizations

Have you ever had any problems with anesthesia? ☐ 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. ________________________________

Family History

	Mother	Father	Brother	Sister
Specific Anesthesia Problem	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐
Ears:				
Hearing Loss before age20	☐	☐	☐	☐
Hearing Loss after age 20	☐	☐	☐	☐
Nose and Sinus:				
Nasal Allergies	☐	☐	☐	☐
Lungs and Respiratory:				
Asthma	☐	☐	☐	☐

	Mother	Father	Brother	Sister
Heart and Blood Vessels:				
Heart Disease	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Brain and Nervous:				
Stroke	☐	☐	☐	☐
Blood & Lymph Node problems:				
Bleeding/clotting problem	☐	☐	☐	☐
Other________________	☐	☐	☐	☐

Social History

What is or was your occupation? ______________________________ ☐ Check here if you are retired.

Have you ever used tobacco in any form? ☐ **No** ☐ **Yes**

If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _______		
Other: (list type) _________		

Do you consume alcohol? ☐ **No** ☐ **Yes**

If yes, please complete the following:

Type of Alcohol	How Much	How often

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

Problems with Endocrine ☐ **No** ☐ **Yes**

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

Problems with Hematological/Lymphatic ☐ **No** ☐ **Yes**

☐ bleed excessively after injury, ☐ bruise easily, ☐ neck masses or lumps

Allergic, Infectious, Immunologic Problems ☐ **No** ☐ **Yes**

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

Musculoskeletal problems ☐ **No** ☐ **Yes**

☐ neck pain

Neurological problems ☐ **No** ☐ **Yes**

☐ headache, ☐ numbness, ☐ severe face pain, ☐ seizure