

Patient History Information

Name: _____ Date: _____
Pharmacy _____ Pharmacy address _____ City: _____

What is the reason for your visit today? _____
How long has the present problem been? _____
What treatments have you had? _____

Please list any allergies to medications: _____

Please list all medications, including aspirin, over the counter medications, birth control:

Past Medical History: Have you ever been treated for the following medical conditions **IN THE PAST? Check yes or no and then circle all that apply.** You may add additional information if necessary.

- Yes No CV Hx: angina, arrhythmia, cath, cardiac disease, heart failure, murmur, heart attack, pacemaker
- Yes No High Blood Pressure _____
- Yes No Skin Diseases (eczema, psoriasis, acne) _____
- Yes No Endocrine Hx: Diabetes, Thyroid Disease (hypo, hyper, Graves Disease)
- Yes No Gastrointestinal Disease (reflux, ulcers, intestinal, hepatitis, cirrhosis) _____
- Yes No Genito-urinary Disease (dialysis, kidney stones) _____
- Yes No HEENT: Allergies (seasonal), cholesteatoma, Meniere's _____
- Yes No Heme: Blood Diseases (anemia, bleeding problems) _____
- Yes No Imm: Cancer (list type or location & date) _____ Chemo ___ Radiation _____
- Yes No Infections (TB, syphilis, HIV) _____
- Yes No Musculoskeletal: Arthritis (rheumatoid, osteo-degenerative), fibromyalgia, TMJ
- Yes No Neurological problems (strokes, seizures, headache, vertigo) _____
- Yes No Mental Health (depression, anxiety, bipolar) _____
- Yes No Respiratory Disease (asthma, bronchitis, COPD, emphysema, pneumonia, sleep apnea) _____
- Yes No use CPAP
- Yes No Other problems: _____

Previous Surgery (date/type) _____

Previous ENT Surgery/Date (tonsils, ear tubes, throat, neck or sinus surgery, etc.) _____

Social History:

- Do you smoke tobacco? Yes No If yes, ___packs per day x ___years.
- Have you ever smoked? Yes No If yes, ___packs per day x ___years. Quit ___y ago
- Do you smoke cigars? Yes No Quit ___y ago
- Do you chew tobacco? Yes No Quit ___y ago
- Do you drink alcohol? Yes No If yes, occasional, moderate or heavy. Quit ___y ago
- Other drug use _____
- Are you pregnant? Yes No Breast Feeding? Yes No LMP _____

SEE OTHER SIDE

Family History: Do you have a family history of disease? Please list the relative.

- Yes No Allergies _____
- Yes No Anesthesia problems _____
- Yes No Bleeding Disorder _____
- Yes No Cancer _____
- Yes No Diabetes _____
- Yes No Hearing Loss _____
- Yes No Heart Disease: heart attack _____ Hypertension _____

Review of Systems: Do you CURRENTLY have any of the following problems?

Check yes or no then circle all that apply:

- Yes No HEENT: bloody nasal discharge, burning sensation in mouth, change in voice, cough, difficulty hearing, difficulty swallowing, ear drainage, ear infection, ear pain, facial fractures, facial swelling, jaw pain, loss of sense of smell or taste, lumps in mouth and neck, mouth bleeding, post-nasal drip, ringing in ears, runny nose, sinus problems, sore throat
- Yes No Allergies: animals, seasonal, itchy eyes, itchy nose, sneezing
- Yes No Respiratory: asthma, difficulty breathing, daytime sleepiness, coughing up blood, difficulty sleeping, shortness of breath, sleep apnea, snoring, wheezing
- Yes No CV: chest pain, edema, elevated BP, heart attack, heart palpitation, irregular heartbeat, pacemaker, shortness of breath with exercise
- Yes No Constitutional: fever, night sweats, tiredness, weight loss
- Yes No Endocrine: high/low blood sugar, thyroid disease
- Yes No Eye problems: abrupt visual loss, dry eyes, itchy eyes, excess tearing, swelling around eyes, red eyes, visual disturbance, double vision
- Yes No GI: abdominal pain, diarrhea, difficulty swallowing, heartburn
- Yes No GU: blood in urine, painful urination
- Yes No Musculoskeletal: Joint Pain
- Yes No Neuro: balance problems, headache, migraines, seizures, stroke, vertigo
- Yes No Mental Health: anxious feelings, depression
- Yes No Derm: dry scaly skin, facial rash, hypertrophic scars, non-healing wound
- Yes No Heme: anemia, bleeding problems, bruise easily, clots in vein or lungs
- Yes No Cosmetic Concerns: facial skin care, Botox, Restylane, other procedures

Signature

Relationship to Patient