Patient Name:	Date:

Gender:	Height:	Weight:	Age:	Date of Birth:

Preferred Pharmacy Name:	Pharmacy Location (Address/City/Street):	Pharmacy Telephone Number: ( ) -
Secondary Pharmacy Name:	Pharmacy Location (Address/City/Street):	Pharmacy Telephone Number: ( ) -

□ I give consent to import and use my medication history from SureScript and agree to verify the retrieved list provided by the Medical Assistant.

Have you ever been diagnosed with the following?	No	Yes
Diabetes		
High Blood Pressure		
Cancer		
Stroke		
Heart Disorder		
High Cholesterol		
Arthritis/Gout		
Convulsions/Seizures		
Bleeding Disorder		
Migraines		
GERD		
Sleep Apnea		
Other:		

If you decline consent to import medication history or if the imported list is incomplete, please include all prescription, over the counters, herbals, and vitamins/minerals/dietary nutritional supplements.

Medications:	Strength	Times/ Day	Treatment of:

Previous ENT Surgeries and History (ex: sinus surgery, septoplasty, tubes, tonsillectomy)	Previous Surgeries/Injuries/Hospitalizations

Social History/Lifestyle Factors					
Alcohol Consumption:	☐Never	☐Previously: # drinks/day:_____	☐Occasionally: # drinks/week:_____	☐Daily: # drinks/day:_____	
Tobacco Use:	☐Never	☐Previously: # packs/day:_____ How long:_____ Quit date:_____		☐Currently: # packs /day:_____	
Second-hand Smoke Exposure:	☐Never	☐Previously		☐Daily	
Recreational Drug Use:	☐Never	☐Previously: Type:_____ How long:_____ Quit date:_____		☐Currently: Type:_____ How long:_____ How often:_____	
Caffeine Use:	☐Never	☐Moderately		☐Daily: # drinks/day:____	
Occupational Exposure:	☐Never	☐Fumes	☐Dust/Airborne Particles	☐Solvents	☐Noise
Type of Residence: ☐House ☐Apartment ☐Dorm ☐Mobile Home ☐Basement Apartment ☐New Construction	Check all that apply: ☐Carpeting ☐Down/Feather Pillows ☐Air Filter ☐Air Conditioning ☐Forced Hot Air ☐Radiator ☐Baseboard Hot Water ☐Water Damage ☐Mold ☐Rodents ☐Roaches ☐Dog(s) ☐Cat(s) ☐Bird(s) ☐Other Pet(s):_____				

Family Medical History	Disease or Illness
Father	
Mother	
Siblings	

Women Only	
Currently Pregnant:	
Currently Breastfeeding:	
Last Menstrual Period:	

Please circle anything that applies to you.

NAME_____ DOB _____ DATE_____

CONSTITUTIONAL SYMPTOMS

- Good general health lately ..... NO YES
- Recent weight change ..... NO YES
- Fever ..... NO YES
- Fatigue ..... NO YES
- Headaches ..... NO YES

EYES

- Eye disease or injury ..... NO YES
- Wear glasses/contact lenses ..... NO YES
- Blurred or double vision ..... NO YES
- Glaucoma ..... NO YES

EARS/NOSE/MOUTH/THROAT

- Hearing loss or ringing ..... NO YES
- Ear aches or drainage ..... NO YES
- Chronic sinus problems ..... NO YES
- Runny nose ..... NO YES
- Nose bleeds ..... NO YES
- Mouth sores ..... NO YES
- Bleeding gums ..... NO YES
- Bad breath or bad taste ..... NO YES
- Sore throat or voice change ..... NO YES
- Swollen glands in neck ..... NO YES

CARDIOVASCULAR

- Heart trouble ..... NO YES
- Chest pain or angina pectoris ..... NO YES
- Palpitations ..... NO YES
- Shortness of breath ..... NO YES
  - With walking or lying flat ..... NO YES
- Swelling of feet, ankles or hands ..... NO YES

RESPIRATORY

- Chronic or frequent coughs ..... NO YES
- Spitting up blood ..... NO YES
- Asthma or wheezing ..... NO YES
- Shortness of breath ..... NO YES

GASTROINTESTINAL

- Loss of appetite ..... NO YES
- Change in bowel movement ..... NO YES
- Nausea or vomiting ..... NO YES
- Frequent diarrhea ..... NO YES
- Painful bowel movement ..... NO YES
- Constipation ..... NO YES
- Rectal bleeding or blood in stool ..... NO YES
- Abdominal pain or heartburn ..... NO YES
- Peptic ulcer (stomach or duodenal) ..... NO YES

MUSCULOSKELETAL

- Joint Pain ..... NO YES
- Joint stiffness or swelling ..... NO YES
- Weakness of muscle or joints ..... NO YES
- Muscle pain or cramps ..... NO YES
- Back pain ..... NO YES
- Cold extremities ..... NO YES
- Difficulty in walking ..... NO YES

INTEGUMENTARY (SKIN/BREAST)

- Rash or itching ..... NO YES
- Change in skin color ..... NO YES
- Change in hair or nails ..... NO YES
- Varicose veins ..... NO YES
- Breast pain ..... NO YES
- Breast lump ..... NO YES
- Breast discharge ..... NO YES

NEUROLOGICAL

- Frequent or recurring headaches ..... NO YES
- Lightheaded or dizzy ..... NO YES
- Convulsions or seizures ..... NO YES
- Numbness or tingling sensation ..... NO YES
- Tremors ..... NO YES
- Paralysis ..... NO YES
- Stroke ..... NO YES
- Head injury ..... NO YES

PSYCHIATRIC

- Memory loss or confusion ..... NO YES
- Nervousness ..... NO YES
- Depression ..... NO YES
- Insomnia ..... NO YES

ENDOCRINE

- Glandular or hormone problems ..... NO YES
- Thyroid disease ..... NO YES
- Diabetes ..... NO YES
- Excessive thirst or urination ..... NO YES
- Heat or cold intolerance ..... NO YES
- Skin becoming dryer ..... NO YES
- Change in hat or glove size ..... NO YES

HEMATOLOGICAL/LYMPHATIC

- Slow to heal after cuts ..... NO YES
- Bleeding or bruising tendency ..... NO YES
- Anemia ..... NO YES
- Phlebitis ..... NO YES
- Past transfusion ..... NO YES
- Enlarged glands ..... NO YES

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

- Penicillin or other antibiotics ..... NO YES
- Morphine, Demerol or other narcotics ..... NO YES
- Novocain or other anesthetics ..... NO YES
- Aspirin or other remedies ..... NO YES
- Tetanus antitoxin or other serums ..... NO YES
- Iodine, Methiolate or other antiseptic ..... NO YES
- Adhesive tape ..... NO YES
- Barbiturates ..... NO YES
- Sulfa ..... NO YES
- Latex ..... NO YES
- ACE Inhibitors ..... NO YES
- Other drug/medication allergies ..... NO YES
  - What? ..... _____
- Food Allergies ..... NO YES
  - What? ..... _____
- Have you ever been allergy tested? ..... NO YES
  - When? ..... _____
- Have you ever had allergy shots? ..... NO YES
  - When? ..... _____

If nothing has changed since your last visit please sign and date

_____ DATE_____
_____ DATE_____
_____ DATE_____
_____ DATE_____
_____ DATE_____

If you need to update this form please ask receptionist to provide a new form.