HEALTH HISTORY

Patient Name:_____ Date:_____

Height:_____ Weight:_____ Date of Birth:_____ Age:_____

Reason for Visit:_____

PAST MEDICAL HISTORY:
Have you ever had any of the following? Please circle YES or NO

Asthma	Yes	No	Hearing Loss	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Infectious Mono	Yes	No
Reflux	Yes	No	Heart Disease	Yes	No
Strep Throat	Yes	No	Bleeding Tendency/Ulcers	Yes	No
Tuberculosis	Yes	No	Nose Bleeds	Yes	No
Thyroid Disease	Yes	No	Hepatitis	Yes	No
Migraine Headaches	Yes	No	Glaucoma	Yes	No
Dizziness/Vertigo	Yes	No	HIV or AIDS	Yes	No
Impacted Ear Wax	Yes	No	Ear Infections	Yes	No
Sleep Apnea	Yes	No	Tinnitus	Yes	No

Please list all hospitalizations and serious illnesses: (include surgeries) _____

_____

_____

Medications: (including prescription and non-prescription) _____

_____

_____

Allergic to any medication: Yes No Please list the name of medicine. _____

_____

Patient Social History: (please circle all that apply)

Excessive exposure to noise: Yes No If yes, what type? _____

Use of alcohol: Yes No Rarely Moderately Daily Socially

Use of tobacco: Yes No Previously Quit Current number packs/day: _____

Use of drugs: Yes No Socially Sometimes Daily Type of drug:_____

Family Medical History: (please circle all that apply)

Father: Cancer / Diabetes / Heart Disease / Hearing Loss / Nosebleeds / Hypertension / Thyroid Disease

Mother: Cancer / Diabetes / Heart Disease / Hearing Loss / Nosebleeds / Hypertension / Thyroid Disease