

ROCKY MOUNTAIN EAR CENTER PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out both pages of this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report. **PLEASE PRINT CLEARLY!**

Social Security Number: (SSN) _____ Appointment Date: _____

Full Name: _____ Male Female Race _____ Date Of Birth: _____

Address: _____ City _____ State: _____ Zip: _____

Home Phone #: () _____ Work Phone # () _____ Cell Phone # () _____

Pharmacy Preference: _____ Address: _____ City: _____ State: _____

Pharmacy Phone #: () _____ Pharmacy Fax #: () _____

Primary Care (Family) Physician: _____ Address: _____

City _____ State: _____ Phone #: _____ Fax #: _____

(TAB 1) Are you taking ANY kind of medication now? (This includes prescription, over-the-counter medications, Vitamins, or Herbal Medications) No Yes If yes, please list below and include dosages.

Medication Name and Dosage	Problem being treated	Date of Prescription	Prescribing Doctor

(TAB 2) ARE YOU ALLERGIC TO ANY MEDICATIONS? No Yes If yes, please list below.

Name of Medication	Type of Reaction

(TAB 3) Are you allergic to anything in the environment such as pollens, dust, food, etc? No Yes

If yes, please indicate what you are allergic to. _____

Have you ever had an allergy test? Skin test: No Yes Blood test: No Yes

(TAB 4) Have you ever been DIAGNOSED with any major health problem? Including but not limited to:

Cancer: (type) _____ No Yes If yes, when _____

Ears: _____

Chronic Ear infections No Yes If yes, when _____

Meniere's Disease No Yes If yes, when _____

Nose and Sinus: _____

Nasal Allergies No Yes If yes, when _____

Heart and Blood Vessels: _____

High / Elevated Cholesterol No Yes If yes, when _____

High Blood Pressure No Yes If yes, when _____

Lungs and Respiratory: _____

Tuberculosis No Yes If yes, when _____

Stomach and Digestive: _____

Duodenal ulcer No Yes If yes, when _____

Hepatitis Type _____ No Yes If yes, when _____

Stomach ulcer No Yes If yes, when _____

Kidney and Gender problems:

Renal Failure No Yes If yes, when _____

Prostate enlargement No Yes If yes, when _____

Are you pregnant? No Yes

Mental and emotional:

Depression No Yes If yes, when _____

Anxiety No Yes If yes, when _____

Glands, Hormones, and Sugar Control:

Diabetes Type _____ No Yes If yes, when _____

Thyroid deficiency No Yes If yes, when _____

Thyroid excess No Yes If yes, when _____

Blood and Lymph Node problems:

Anemia No Yes If yes, when _____

Allergies, Immune and Infection problems:

HIV No Yes If yes, when _____

Infectious mononucleosis No Yes If yes, when _____

Have you ever been DIAGNOSED with any other major health problem not listed above? No Yes If yes, please list the diagnosis and the year the diagnosis was made. _____

(TAB 5) SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? No Yes

If yes, please list what sort of problem. _____

Have you ever had 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 the admission and the date. _____

(TAB 8) FAMILY HISTORY

- Family History Not Known
- No Family with Significant or Pertinent Health problems.
- Specific Anesthesia Problem** Mother Father Brother Sister
- Ears:**
- Hearing Loss before age 20 Mother Father Brother Sister
- Hearing Loss after age 20 Mother Father Brother Sister
- Nose and Sinus:**
- Nasal Allergies Mother Father Brother Sister
- Heart and Blood Vessels:**
- Heart Disease Mother Father Brother Sister
- High Blood Pressure Mother Father Brother Sister
- Lungs and Respiratory:**
- Asthma Mother Father Brother Sister
- Lung Cancer Mother Father Brother Sister

Skin and/or Breast:

- Breast Cancer Mother Father Brother Sister
- Skin Cancer Mother Father Brother Sister

Brain and Nervous:

- Stroke Mother Father Brother Sister

Blood and Lymph Nodes:

- Bleeding/Clotting Problems Mother Father Brother Sister

Other _____ Mother Father Brother Sister

Other _____ Mother Father Brother Sister

(TAB 9) SOCIAL HISTORY

What is your occupation? _____ Check if you are retired.

What is your marital status? Single Married Widowed Divorced Legally Separated

Have you ever used tobacco in any form? No Yes Do you consume alcohol? No Yes

If yes, Please complete the following:

If yes, please complete the following:

TYPE OF TOBACCO	FROM YEAR	TO YEAR
Cigarettes per day: _____		
Other: (list type) _____		

TYPE OF ALCOHOL	HOW MUCH	HOW OFTEN

Are you exposed to second hand smoke? No Yes

Is there a personal history of substance abuse? No Yes

If yes, please explain _____

(TAB 10) REVIEW OF SYSTEMS: Have you had or have you recently had any of the following:

General health problems?

(Fever, weight loss, problems sleeping etc) No Yes

If yes, please list _____

Head or Face problems?

(Headache, face pain, etc.) No Yes

If yes, please list _____

Eye problems that are not correctable with glasses?

(Double vision, glaucoma, cataracts, etc.) No Yes

If yes, please list _____

Ear problems?

(Drainage, hearing loss, ringing, dizziness, etc.) No Yes

If yes, please list _____

Nose and Sinus problems?

(Obstruction, etc) No Yes

If yes, please list _____

Mouth and Throat problems?

(Frequent sore throat, mouth sores, hoarseness, etc) No Yes

If yes, please list _____

Neck Problems?

(Lumps, masses, pain swollen glands, etc.) No Yes

If yes, please list _____

Heart or Circulation problems? (Blacking out or fainting, bluish discoloration of lips or fingernails, chest pain, irregular heartbeat, swelling of legs and feet and / or ankles, leg cramps, etc)

No Yes

If yes, please list _____

Do you drink caffeinated beverages? No Yes

If yes, how much _____

Stomach Problems?

(Pain, heartburn, nausea, vomiting, diarrhea, bleeding, etc) No Yes

If yes, please list _____

Kidney, bladder or gender related problems? (Burning, bleeding, Change in urinary pattern, problems passing urine, prostate problems, Ovarian cysts, Etc.)

No Yes

If yes, please list _____

Bone, Joint or muscle Problems?

(Painful joints, muscles, bone deformities, etc.) No Yes

If yes, please list _____

Skin or Breast Problems?

(Skin rash, sore tender nipples, etc.) No Yes

If yes, please list _____

Brain or Nervous system problems?

(Seizures, numb areas, nerve problems, headache, etc.) No Yes

If yes, please list _____

Mental or Emotional problems?

(depression, anxiety, suicidal thoughts, etc.) No Yes

If yes, please list _____

Problems bleeding freely, bruising excessively, or other blood problems?

No Yes

Allergies or Frequent infections in different areas of your body?

No Yes

If yes, please list _____

FOR OFFICE USE ONLY: Reviewed by: _____ Date: _____

Notes: _____