Rocky Mountain EAR CENTER, P.C.

# 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 your electronic medical record. PLEASE PRINT CLEARLY!

Social Security Number (SSN) ________________ Appointment Date ________________

Full Name ________________ Date Of Birth ________________ ☐ Male ☐ Female

Address ________________ City ________________ State ________ Zip ________

Home Phone # ________________ Work Phone # ________________ Cell Phone # ________________

What is your occupation? ________________ ☐ Check if you are retired.

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

PRIMARY Pharmacy Preference ________________

Address ________________ City ________________ State ________ Zip ________

Pharmacy Phone # ________________ Pharmacy Fax # ________________

Primary Care (Family) Physician ________________

Address ________________ City ________________ State ________ Zip ________

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:**

**Ears**

Chronic Ear infections ☐ No ☐ Yes If yes, when ________

Meniere's Disease ☐ No ☐ Yes If yes, when ________

**Kidney and Gender Problems**

Renal Failure ☐ No ☐ Yes If yes, when ________

Prostate enlargement ☐ 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 ______

**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 ______

**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**
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**

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

If yes, please complete the following

| Type of Tobacco | From Year | To Year |
|---|---|---|
| Cigarette per day ______ | | |
| Other (list type) ______ | | |

Are you exposed to second hand smoke? ☐ No ☐ Yes

Is there a personal history of substance abuse? ☐ No ☐ Yes

If yes, please explain ______

Do you consume alcohol? ☐ No ☐ Yes

If yes, please complete the following

| Type of Alcohol | How Much | How Often |
|---|---|---|
| | | |
| | | |

Do you drink caffeinated beverages? ☐ No ☐ Yes

If yes, how much? ______

**(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 ______________________________

**Noes 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 ______________________________

**Stomach problems?**

(Pain, Heartburn, Nausea, Vomiting, Diarrhea, Bleeding, etc.)

☐ No ☐ Yes If yes, please list ______________________________

**Kidney, Bladder or General 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 If yes, please list ______________________________

Allergies or Frequent Infection in Different Areas of your Body?

☐ No ☐ Yes If yes, please list ______________________________

**For Office Use Only:** Reviewed by ___________ Date ___________

Notes ______________________________

**MU Form Revision: 9/2014**