Patient Health History Form

Name: ______________________________ Age: ______ Today's Date: ____/____/____

Who referred you?______________________ Regular Family Doctor:______________________

Reason for visit:______________________ Pharmacy Name ______________________

Pharmacy address______________________ City______________________

State ______________ Zip Code______________ Pharmacy Phone #______________________

Date of Onset - Estimate when the above problem first began: ___/___/___

Review of Systems/ PMH: Are you currently, or have you had, problems with: *Please circle all that apply*

Was last hearing test >6 months ago? *Yes / no* (If so, a new test may need to be done to evaluate ear problems.)

Hearing	Ear fullness	Better ear: L / R?	Ringing in the ears	Discharge	Hearing aid L / R?
Dizziness	Vertigo	(spinning sensation)	Sense of imbalance		Lightheadedness
Nasal obstruction	Sinusitis	Headaches	Post nasal drip	Allergies	Fainting Spells
Voice disturbance	Hoarseness	Heartburn	Swallowing difficulty		Throat clearing
Pain / tenderness	ears	nose	throat	neck	elsewhere:
Lump/mass in the	ears	nose	throat	neck	elsewhere:

Allergies (immune-13)	y / n	Autoimmune / Lupus	y / n	Arthritis (musculoskel-11)	y / n
Immunology disorder	y / n	Anemia (Heme/ lymph-12)	y / n	Swelling legs	y / n
Back Pain	y / n	**Blood Transfusion**	y / n	Stroke	y / n
Bleeding problems	y / n	**Heart Murmur**	y / n	Migraines	y / n
Chest Pain or Angina	y / n	**Heart Attack** (CV-6)	y / n	Brain tumor	y / n
Depression (Psy-3)	y / n	Irregular Pulse	y / n	Memory Problems	y / n
Hormone Problems	y / n	Congestive Heart failure	y / n	Other Psychiatric	y / n
Other Eye Problems	y / n	Diabetes (Endocrine-8)	y / n	**Prostate problems**	y / n
Fever (Constitutional-1)	y / n	Endocrine/ Thyroid	y / n	Lung disease	y / n
Urination Problems	y / n	Excessive Fatigue	y / n	Chronic Cough	y / n
Headaches (Neuro-2)	y / n	Glaucoma (Eye-5)	y / n	Bloody Sputum	y / n
Swollen glands	y / n	Cataracts	y / n	Pneumonia	y / n
Nausea	y / n	**Ulcers or Gastritis**	y / n	Asthma	y / n
Neurological problems	y / n	**Liver** problems (GI-7)	y / n	Emphysema	y / n
Seizures	y / n	Hepatitis	y / n	Tuberculosis (Lung-9)	y / n
Skin problems (Skin-4)	y / n	Abdominal Pain	y / n	Night Sweats	y / n
Snoring / Sleep apnea	y / n	Crohn's / U.C.	y / n	Skin Cancer	y / n
Weakness	y / n	High Blood Pressure	y / n		

Weight change / loss y / n Cancer Type: Cervical, Uterine, Breast, Colon, ENT, Lung, Prostate, Other y / n

Other info: ____

Major Trauma y / n What happened? ______________________________

If female, is there any possibility that you are pregnant? *Yes / No* Have you ever had problems with anesthesia? *Yes / No*

Please list any prior major illnesses and/or injuries:______________________

Surgeries / Hospitalizations	Year	Complications	Surgeries / Hospitalizations	Year	Complications

Have you ever had: ☐ Ear Surgery ☐ Mastoidectomy (Ear) ☐ Stapedectomy ☐ Tonsils and adenoids ☐ Nasal Surgery ?

Medications: Have you taken any of the following within the past two weeks? ☐ Aspirin ☐ Motrin

Blood pressure medication? ______________________ Birth-control Pills?______________________

What other medications do you take? (please list) ______________________________

____

Vitamins? ____

Social History: Married: ___ Single:___ Divorced___ Widow(er)___ # of Children:__________

Current Occupation: ______________________________ Retired? *Y / N* pre-retirement job:__

Have you ever smoked? *Y / N* # packs per day ______...for how many years? _____ I have quit, ___# years ago.

Do you drink alcohol? ☐ Never or rarely ☐ Quit ☐ Yes, daily ☐ 1 or more times a week ☐ 1 or more times a month

Do you or have you used: ☐ Cocaine ☐ Afrin ☐ Intravenous drugs

Do you know your HIV status? ☐ Positive ☐ Negative ☐ Don't know

Allergies: Are you allergic to: ☐ Sulfa ☐ Penicillin ☐ Shellfish ☐ Iodine ☐ Other __________

Family History (code M for mother, F for father, S for siblings)

☐ Immune problems	☐ Cancer	☐ Allergies	☐ Hearing problems	☐ Otosclerosis
☐ Bleeding disorders	☐ Cystic fibrosis	☐ Migraines	☐ Heart attack	☐ Stroke
☐ Brain tumor	☐ Diabetes	☐ Lupus	☐ Coronary disease	☐ Thyroid disorders

Other significant Family history: ______________________________

Please write in anything else we should know about your history that was not covered on this sheet.

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Patient Signature	Date:	I have reviewed the above information with the patient. John Li, MD