_____ Date of Birth: _____

Referring Doctor: _____

Reason for visit: _____

What applies currently:

- ☐ Allergy
- ☐ Asthma
- ☐ Anxiety
- ☐ Cough
- ☐ Ear Pain
- ☐ Ease of bleeding or bruising
- ☐ Fatigue
- ☐ Glasses or contacts
- ☐ Hearing loss
- ☐ Heartburn
- ☐ Muscle weakness
- ☐ Rash
- ☐ NONE

All Surgeries & Appx. Year:

☐ NONE

_____

_____

_____

_____

_____

Medications inc. Vitamins & Supplements

☐ NONE

_____

_____

_____

_____

Are you under a Pain Management program?

☐ Yes ☐ No

Chronic Medical Illnesses:

- ☐ Allergy
- ☐ Asthma
- ☐ Cancer Type/year_____
- ☐ Diabetes
- ☐ Heart Attack Date_____
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Seizure
- ☐ Sleep Apnea CPAP?
- ☐ NONE

Drug Allergies (list w/reaction)

☐ NONE

_____

_____

_____

_____

Allergic to Latex?

☐ Yes ☐ No

☐	Acid Reflex/GERD	☐ Mom	☐ Dad	☐ Siblings
☐	Thyroid Disease	☐ Mom	☐ Dad	☐ Siblings
☐	Sleep Apnea	☐ Mom	☐ Dad	☐ Siblings
☐	Chronic Ear Disease	☐ Mom	☐ Dad	☐ Siblings
☐	Childhood Hearing Loss	☐ Mom	☐ Dad	☐ Siblings

Immunizations:

Flu Vaccine ☐ Yes ☐ No Month/Year _____

Pneumonia ☐ Yes ☐ No Month/Year _____

Smoking History:

☐ Never ☐ Former ☐ Current

_____ ppd for _____ years

Quit smoking _____ year

Alcohol History:

☐ Yes ☐ No ☐ Current

drinks per week_____