PROVIDER:

PLEASE PROVIDE THE FOLLOWING INFORMATION TO THE BEST OF YOUR ABILITY:

PATIENT NAME:
MRN:
DOB:

WHAT PROBLEM(S) ARE YOU HERE FOR TODAY? _____

IS THE CURRENT PROBLEM A RESULT OF ☐ WORK ACCIDENT ☐ AUTO ACCIDENT ☐ OTHER _____

PAST MEDICAL HISTORY:

1) PLEASE CHECK THE 'YES' OR 'NO' BOX TO INDICATE IF YOU HAVE/HAD ANY OF THE FOLLOWING ILLNESSES FOR 'YES' ANSWER PLEASE EXPLAIN:

	YES	NO			YES	NO	
DIABETES	☐	☐		KIDNEY PROBLEMS	☐	☐	
HIGH BLOOD PRESSURE	☐	☐		NEUROLOGICAL PROBLEMS	☐	☐	
HEART DISEASE	☐	☐		CANCER	☐	☐	
BLEEDING DISORDER	☐	☐		DEPRESSION / ANXIETY	☐	☐	
LUNG (ASTHMA, BRONCHITIS)	☐	☐		ALLERGY PROGLEMS / THERAPY	☐	☐	
LIVER PROBLEMS	☐	☐		OTHER MEDICAL PROBLEMS	☐	☐	

2) PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS (AND DATES) YOU HAVE EVER HAD (INCLUDING TONSILS & ADENOIDS):

SURGERIES / HOSPITALIZATIONS	YEAR	SURGERIES / HOSPITALIZATIONS	YEAR

ANESTHESIA PROBLEMS: ☐ YES ☐ NO _____

3A) PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING DOSAGE AND TIMES PER DAY):

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

3B) LIST ANY ALLERGIES TO MEDICATIONS: _____

FAMILY HISTORY:

1) PLEASE CHECK THE 'YES' OR 'NO' BOX TO INDICATE WHETHER ANY RELATIVES HAVE ANY OF THE FOLLOWING ILLNESSES/ PROBLEMS:
2) FOR 'YES' PLEASE INDICATE WHICH RELATIVE(S) HAS/HAVE THE PROBLEM AND EXPLAIN:

	YES	NO	
HEARING LOSS	☐	☐	
BLEEDING DISORDER	☐	☐	
CANCER	☐	☐	
HEART DISEASE	☐	☐	
DIABETES	☐	☐	
ANESTHESIA PROBLEMS	☐	☐	
OTHER MEDICAL PROBLEMS	☐	☐	

PHARMACY INFORMATION:

PHARMACY NAME: _____

PHARMACY PHONE: _____

PHARMACY ADDRESS: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____

PATIENT NAME:
MRN
DOB:

SOCIAL HISTORY:

ARE YOU PRESENTLY: ☐ WORKING ☐ RETIRED ☐ DISABLED OCCUPATION (OR PREVIOUS OCCUPATION): _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

DO YOU HAVE CHILDREN? ☐ YES ☐ NO HOW MANY? _____ DO YOU LIVE ALONE? ☐ YES ☐ NO

DO YOU USE TOBACCO?

- ☐ YES, I HAVE SMOKED _____ PACK(S) OF CIGARETTES PER DAY FOR _____ YEARS
- ☐ YES, I SMOKE CIGARETTES OCCASIONALLY, BUT NOT EVERYDAY
- ☐ YES, I SMOKE CIGARS OR A PIPE
- ☐ YES, I CHEW TOBACCO
- ☐ NO, I QUIT SMOKING _____ YEARS AGO. AT THE TIME I WAS SMOKING _____ PACK(S) PER DAY FOR _____ YEARS
- ☐ NO, I HAVE NEVER SMOKED

DO YOU DRINK ALCOHOL?

- ☐ YES, DAILY
- ☐ YES, 1 OR MORE TIMES PER WEEK
- ☐ YES, 1 OR MORE TIMES PER MONTH
- ☐ NO, BUT I HAVE PREVIOUSLY
- ☐ NO, NEVER (OR RARELY)

DO YOU USE RECREATIONAL DRUGS?

- ☐ YES, PRESENTLY TYPE/FREQUENCY _____
- ☐ NO, BUT I HAVE PREVIOUSLY TYPE/FREQUENCY _____
- ☐ NO

CAFFEINE INTAKE: _____ PER DAY EXERCISE: ☐ YES ☐ NO TYPE/FREQUENCY _____

HAVE YOU BEEN EXPOSED TO SIGNIFICANT NOISE? (FACTORY WORK, GUNS, MILITARY) ☐ YES ☐ NO TYPE/FREQUENCY _____

ARE YOU AT RISK FOR AIDS? (DRUG ABUSE, PREVIOUS BLOOD TRANSFUSION, ETC.) ☐ YES ☐ NO

REVIEW OF SYSTEMS:

1) PLEASE CHECK THE 'YES' OR 'NO' BOX TO INDICATE WHETHER YOU PRESENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS:
2) FOR ANY 'YES' ANSWERS, PLEASE CHECK THE 'CURRENT' BOX, IF THIS SYMPTOM RELATES TO THE REASON FOR YOUR VISIT TODAY:

		YES	NO	CURRENT		YES	NO	CURRENT
GENERAL	FEVER	☐	☐	☐	WEIGHT LOSS ☐ OR GAIN ☐	☐	☐	☐
	CHRONIC FATIGUE	☐	☐	☐				
	NIGHT SWEATS	☐	☐	☐				
EYES	WEAR GLASSES	☐	☐	☐	INJURIES / TRAUMA	☐	☐	☐
	WATERY/ITCHY EYES	☐	☐	☐				
	VISION CHANGES	☐	☐	☐				
CARDIOVASCULAR	CHEST PAIN	☐	☐	☐	IRREGULAR PULSE	☐	☐	☐
RESPIRATORY	CHRONIC COUGH	☐	☐	☐	SHORTNESS OF BREATH	☐	☐	☐
NEUROLOGICAL	FAINTING	☐	☐	☐	CHRONIC HEADACHE	☐	☐	☐
	FACIAL NUMBNESS	☐	☐	☐				
PSYCHIATRIC	DEPRESSION	☐	☐	☐	ANXIETY	☐	☐	☐
	SCHIZOPHRENIA	☐	☐	☐	MANIC / DEPRESSION	☐	☐	☐
SKIN	RASH	☐	☐	☐	ITCHING	☐	☐	☐
	HIVES	☐	☐	☐	SKIN LESION(S)	☐	☐	☐
MUSCULOSKELETAL	JOINT PAIN	☐	☐	☐	MUSCLE PAIN	☐	☐	☐
GI	NAUSEA	☐	☐	☐	VOMITING	☐	☐	☐
	HEARTBURN	☐	☐	☐				
	DIFFICULTY SWALLOWING	☐	☐	☐				
ENDOCRINE	EXCESSIVE THIRST	☐	☐	☐	FEEL WARMER THAN OTHERS	☐	☐	☐
					FEEL COOLER THAN OTHERS	☐	☐	☐
HEME / LYMPH	SWOLLEN GLANDS	☐	☐	☐	BLEEDING PROBLEMS	☐	☐	☐
ALLERGY	FOOD ALLERGIES	☐	☐	☐	INHALANT ALLERGIES	☐	☐	☐
	ENVIRONMENTAL ALLERIES	☐	☐	☐				
ENT	EAR PAIN	☐	☐	☐	EAR DRAINAGE	☐	☐	☐
	EAR PRESSURE	☐	☐	☐	TINNITUS / EAR NOISES	☐	☐	☐
	HEARING LOSS	☐	☐	☐	VERTIGO (SPINNING)	☐	☐	☐
	IMBALANCE	☐	☐	☐	NASAL CONGESTION	☐	☐	☐
	HOARSENESS	☐	☐	☐	SORE TROAT	☐	☐	☐
	WEAR HEARING AID	☐	☐	☐	SNORING	☐	☐	☐
	SINUS PAIN	☐	☐	☐	RUNNY NOSE	☐	☐	☐
	JAW CLENCHING	☐	☐	☐	POST-NASAL DRAINAGE	☐	☐	☐
	TOOTH-GRINDING	☐	☐	☐	SNEEZING	☐	☐	☐
	DAYTIME SLEEPINESS	☐	☐	☐				

REVIEWED BY: _____ DATE: _____