Medical History

Date _____

Patient Name _____Birthday _____

Patient Hx		Condition	Mothers Hx		Fathers Hx	
Yes	No	Low Blood Pressure Problems	Yes	No	Yes	No
Yes	No	High Blood Pressure Problems	Yes	No	Yes	No
Yes	No	Irregular Heartbeat	Yes	No	Yes	No
Yes	No	Heart Disease	Yes	No	Yes	No
Yes	No	Stroke	Yes	No	Yes	No
Yes	No	Diabetes	Yes	No	Yes	No
Yes	No	Anemia	Yes	No	Yes	No
Yes	No	Swelling of Hands and Feet				
Yes	No	Trouble Sleeping				
Yes	No	Stress/Anxiety Level: ___ mild ___ moderate ___ severe				
Yes	No	Hx of Head Injury - Date _____				
Yes	No	Severe Infections (long- term Antibiotics)				
Yes	No	Exposure to Toxic Fumes and Chemicals				
Yes	No	Caffeine Intake – how much: _____				
Yes	No	Tobacco Use – how much: _____				
Yes	No	Alcohol Consumption – how much: _____				
Yes	No	Salt Use: _____ low _____moderate _____high				

Current Activities/ Profession:_____

_____

Married Y N **Children** Y N

Other Medical Problems (please circle all that apply)

Eyes	Allergy	Weight loss	Muscles/joints
Ears	Neurologic	Colon	Thyroid/glands
Nose	Psychiatric	Stomach	Blood Disorder
Throat	Migraine	Bladder/Kidney	Other:
Lungs	Skin	Prostate	_____

List all operations and the date they happened

Operations	Date

Reviewed both sides of form by:

_____Date _____

Medical History

Date _____

Drug Allergies:	**Reaction**
Vaccinations:	**Date Received**
COVID-19	
Influenza	
Pneumococcal	

Medications

Please list all medication currently taking,

Medication:	Dose:	Reason & start date:

☐ Place a check mark here if you have additional medications listed on a separate page and have attached to this form

List your preferred Pharmacy

Name_____

Address_____

City _____ St _____ ZIP_____

Phone # _____FAX # _____

Please list anything else you believe the Physician should know about you:

_____

The Balance and Ear Center is permitted to release information on my medical health to: *(list a name and phone if possible)*

☐ *Spouse* _____

☐ *Immediate family*_____

☐ *Primary Provider* _____

☐ *Others – Please list* _____

*Initials of Reviewer*_____