Medical History

Date ______________

Patient Name ___________________________________ MRN _____________

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/ Jobs:____

____

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

Medications

Please list all medication currently taking

Medication:	Dose:	Reason & start date:

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:

- ☐ *Spouse*
- ☐ *Immediate family*
- ☐ *Primary Provider* __________________________
- ☐ *Others – Please list*

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