Patient's Name: _____ **Date of Birth:** _____

Preferred Pharmacy: _____ **Mail-away Pharmacy:** _____
Pharmacy Location: _____

Drug Allergies

Are you allergic to any medications? ☐ NO ☐ YES (please list below the medication and your reaction)

MEDICATION	What was your reaction?

Family History (not your personal history):

Please mark if any one in your family has had any of the following conditions. If a family member died from this condition, please record in the Comment field which family member and his/her age at death.

Please check	Condition	Comment *Please enter any details that may be pertinent. If a family member died because of the condition, please enter the family member and age that he/she died.*
☐	Allergies	
☐	Asthma	
☐	Autoimmune disease	
☐	CAD (Coronary Artery Disease)	
☐	Cancer	
☐	Cleft lip/palate	
☐	CVA (stroke)	
☐	Depression	
☐	Developmental Delay	
☐	Diabetes	
☐	GERD	
☐	Hearing disorder	
☐	Hematological disorder	
☐	Hyperlipidemia	
☐	Hypertension (High Blood Pressure)	
☐	Migraines	
☐	Obesity	
☐	Chronic Otitis Media	
☐	Otosclerosis	
☐	Renal disease	
☐	Seizure disorder	
☐	Sickle cell disease	
☐	Sleep apnea	
☐	Thyroid disorder	
☐	Complications related to anesthesia	
☐	_____	
☐	_____	

Adult Patients only—Social History

Occupation: _____

Please check your **employment status**: ☐ FT ☐ PT ☐ unemployed ☐ retired ☐ disabled

Please check your **Marital Status**: ☐ single ☐ married ☐ life partner ☐ separated ☐ divorced ☐ widowed

Tobacco Use: ☐ Current ☐ Former ☐ Never **Alcohol Use**: ☐ No ☐ Yes ☐ Former

If you marked current or former, please fill out below:
Type_____
Units per Day _____
Years Used _____

If you marked yes or former, please fill out below:
Type_____ Daily Amount_____
Frequency_____ Last Drink_____

Pediatric Patients only—Social History

The pediatric patients resides with _____
Who has legal custody of the pediatric patient? _____

Does anyone in the home smoke? ☐ NO ☐ YES
Does the pediatric patient attend daycare? ☐ NO ☐ YES if so, for how many days per week? _____

Patient's Past Medical History: Please mark if you have or have had any of the following. If you have a condition not listed, please enter in the blanks provided.

☐ Anemia	☐ COPD	☐ Headaches	☐ Migraines
☐ Anxiety	☐ Coronary artery disease	☐ Heart disease	☐ Multinodular goiter
☐ Arthritis	☐ CVA	☐ High cholesterol	☐ Otosclerosis
☐ Asthma	☐ Depression	☐ Hypertension	☐ Seasonal Allergies
☐ Birth disorder	☐ Diabetes	☐ Hyperthyroidism	☐ Seizure disorder
☐ Bleeding disorder	☐ Emphysema	☐ Hypothyroidism	☐ Sleep disorder
☐ Cancer	☐ GERD	☐ Intestinal disorder	☐ Stomach ulcer
☐ Chronic infection	☐ ENT Syndromes	☐ Irregular heart rate	☐ Tinnitus
☐ Congestive heart failure	☐ Grave's disease	☐ Kidney disorder	☐ Vertigo
☐ Complications related to anesthesia	☐ _____	☐ _____	☐ _____

Patient's Past Surgical History: Please list any surgeries you have had and the approximate date.

Surgery	Appx. Date

_____ _____
Signature Date