Patient History

Patient Name: ______________________ Today's Date: ______________________

DOB: ______________________ EMR#: ______________________

B/P: ________ / ________ P: ____________ O2: ____________ %. Wt: ____________ Ht: ____________

Allergies: ☐ Latex ☐ Medical Tape ☐ Iodine

Allergies to Medication	Type of Reaction	Other Allergies	Type of Reaction

Current Medication: (Prescription and Over-the-Counter) ☐ None (Please attach list if needed)

Medication Name	Dosage	How Often	Medication Name	Dosage	How Often
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.			14.		

Reason for today's visit: ____

____

Past Medical History: (Please check ALL that apply to patient)

- ☐ ADHD/ADD
- ☐ Asthma
- ☐ Cataracts
- ☐ Emphysema
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Lupus
- ☐ Reflux
- ☐ Stroke
- ☐ Anemia
- ☐ Cancer: ______________
- ☐ COPD
- ☐ Glaucoma
- ☐ Hepatitis: Type: A B C
- ☐ HIV/AIDS
- ☐ Migraines
- ☐ Renal failure
- ☐ Tuberculosis
- ☐ Anxiety
- ☐ Depression
- ☐ Healthy
- ☐ Hiatal hernia
- ☐ Hyperthyroid (excess)
- ☐ Mononucleosis
- ☐ Sleep apnea/CPAP
- ☐ Arthritis
- ☐ Diabetes: Type 1 Type 2
- ☐ Heartburn
- ☐ High blood pressure
- ☐ Hypothyroid (deficiency)
- ☐ Prostate enlargement
- ☐ STD: Type: ____________
- ☐ Other: ______________

To be completed by the nurse: CQM Questions

History of High B/P: Med Controlled (all, age 18+) ☐ Yes ☐ No

Cervical CA Screening (girls, age 23+) ☐ Yes ☐ No

Colorectal CA Screening (all, age 50+) ☐ Yes ☐ No

Use of Asthma Medication (all, age 5+) ☐ Yes ☐ No

Chlamydia Screening (girls, age 15+) ☐ Yes ☐ No

Breast CA Screening (girls, age 40+) ☐ Yes ☐ No

Flu Shot (all, age 6 months+) ☐ Yes ☐ No

Pneumonia Shot (all, age 65+) ☐ Yes ☐ No

Fall Risk Screening (all, age 65+) ☐ Yes ☐ No

Tobacco Intervention (all, age 14+) ☐ Yes ☐ No

TURN OVER

ENT Specific Surgery:

Ear Tubes (BMTT) Where/When: ____________________
Ear Surgery (Internal) Where/When: ____________________
Ear Surgery (External) Where/When: ____________________
Nasal Surgery Where/When: ____________________
Sinus Surgery Where/When: ____________________
Tonsils Where/When: ____________________
Adenoids Where/When: ____________________

Any other surgeries since birth (head to toe):

Type of Surgery: ____________________ When/ Where: ____________________
Type of Surgery: ____________________ When/ Where: ____________________
Type of Surgery: ____________________ When/ Where: ____________________
Type of Surgery: ____________________ When/ Where: ____________________
Type of Surgery: ____________________ When/ Where: ____________________

Any HEAD or NECK – CT – MR – X-RAYS done in the last six months? ☐ Yes ☐ No
If so, when and where? ____________________

Family Medical History:

Check all of the following that apply to immediate family members, meaning mother, father, grandparents, brothers or sisters.

☐ Allergies
☐ Hypertension
☐ Bleeding Disorders
☐ Dementia
☐ Mental Illness
☐ Cancer: Type? __________

☐ Hearing loss
☐ Heart Disease
☐ Asthma
☐ Migraines
☐ Other: __________

☐ Coronary Artery Disease (CAD)
☐ Diabetes. ☐ Type 1 ☐ Type 2
☐ COPD
☐ ADD / ☐ ADHD
☐ Other: __________

☐ Stroke (CVA)
☐ Obesity
☐ Alzheimer's Diseased
☐ Alcoholism
☐ Unknown/Adopted

Social History: *Check all that apply to the patient.*

Do you drink alcohol? ☐ Yes ☐ No ☐ Former
How often? ☐ Daily ☐ Occasionally ☐ Rarely
Tobacco Use? (age 14+) ☐ Yes ☐ No ☐ Former __________ Age Started __________ Age Quit
☐ Cigarette ☐ Cigar ☐ E-cig ☐ Vape ☐ Other __________. __________# of packs per day.

Pediatric Patients: *(Birth to age 18)*

Exposed to secondhand smoke? ☐ Yes ☐ No
Was the child premature at birth? ☐ Yes ☐ No If yes, how many weeks? ____________________
Attends daycare? ☐ Yes ☐ No
Attends school? ☐ Yes ☐ No

Nurse Initials: ____________________