PATIENT MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Today's Date: _____

Please list the name of your doctor:

Primary Care: _____ City: _____ Phone: _____

Referring/Other: _____ City: _____ Phone: _____

Have you ever had an audiogram (hearing test)? ☐ YES ☐ NO

If you wear a HEARING AID, where did you purchase it/them? _____

Allergies to medications and reactions: _____

Current medications, including OTC and supplements:

_____

_____

Vitals: Weight: _____ **Height:** _____

Tobacco Use: 12 years and older

☐ **Not a Smoker**

☐ **Current Smoker**

How often do you smoke cigarettes?

- ☐ Every day
- ☐ Some days, but not every day

How many cigarettes do you smoke?

- ☐ 5 or less
- ☐ 6-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31 or more

How soon after you wake up do you smoke your first cigarette?

- ☐ Within 5 minutes
- ☐ 6-30 minutes
- ☐ 31-60 minutes
- ☐ After 60 minutes

Are you interested in quitting?

- ☐ Ready to quit
- ☐ Thinking about quitting
- ☐ Not ready to quit

☐ **Former Smoker**

How long has it been since you last smoked?

- ☐ Less than 1 month
- ☐ 1-3 months
- ☐ 6-12 months
- ☐ 1-5 years
- ☐ 5-10 years
- ☐ Greater than 10 years

Do you drink? ☐ YES ☐ NO **If yes, how much and for how many years?** _____

Do you use marijuana or other drugs? ☐ YES ☐ NO

Have you been diagnosed with Sleep Apnea? ☐ YES ☐ NO **If yes, onset date?** _____

Current Sleep Apnea therapy? ☐ YES ☐ NO If yes, CPAP or _____

Do you have the following illnesses?

Diabetes	☐	Dementia/Alzheimer's	☐	AIDS/HIV	☐
Bleeding Disorders	☐	Stroke	☐	HEPATITIS C	☐
Heart Disease	☐	Hearing Loss	☐	Neurologic Problems	☐
Anesthesia Problems	☐	Thyroid	☐	Immune Deficiency	☐
High Blood Pressure	☐	Cancer	☐	Transplant Surgery	☐
Kidney Disease	☐	Type of Cancer: _____		Others: _____	
Lung/Asthma	☐	OCA/CPAP	☐		

Surgeries: _____

_____

Hospitalization: _____

_____

Advance Care Planning (for patients age 65 and over):

☐ No Advance Directive on File

☐ Power of Attorney: ☐ Yes ☐ No (If yes, please provide)

☐ Surrogate Decision Maker: ☐ Yes ☐ No (If yes, please provide)

	Reviewed by Patient	Provider Initials	Date
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____