



# Medical History

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Birthday \_\_\_\_\_

<b>Patient Hx</b>		<b>Condition</b>	<b>Mothers Hx</b>		<b>Fathers Hx</b>	
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 \_\_\_\_\_

<b><u>Drug Allergies:</u></b>	<b><u>Reaction</u></b>
<b><u>Vaccinations:</u></b>	<b><u>Date Received</u></b>
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:*

\_\_\_\_\_  
 \_\_\_\_\_

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*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* \_\_\_\_\_