

Name:		Date of Birth:		Today's Date:	
e-mail address:			Height:		Weight:
PATIENT SOCIAL HISTORY					
Present or Past Occupation:				<input type="checkbox"/> Retired <input type="checkbox"/> Woodworker?	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks/week? When did you quit?		Tobacco: <input type="checkbox"/> Never <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> 2 nd Hand Smoke <input type="checkbox"/> Chew/Snuff <input type="checkbox"/> Quit, finish below How old were you when you started? & Quit?		Recreational Drugs: <input type="checkbox"/> Never <input type="checkbox"/> Marijuana Other	
Caffeine: <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks/week?		How would you rate your lifestyle? <input type="checkbox"/> Active <input type="checkbox"/> Moderate <input type="checkbox"/> Sedentary			
Do you have a living will or Advanced Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No, Where?					
FAMILY MEDICAL HISTORY					
Has anyone in your immediate family (parents/brothers/sisters) had... <input type="checkbox"/> None of These					
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Ear - Otosclerosis	<input type="checkbox"/> Kidney Disease		
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Mental Illness		
<input type="checkbox"/> Angina (Chest Pain)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Stroke		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Ear - Hearing Loss	<input type="checkbox"/> Headaches	<input type="checkbox"/> Thyroid Problem		
<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Ear - Deafness	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Ear - Meniere's Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Skin Cancer		
<input type="checkbox"/> Birth Defects – type?					
Are you aware of any hereditary (familial) medical conditions in your family?					
PATIENT MEDICAL HISTORY					
Do you have or have you ever had... <input type="checkbox"/> None of These					
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Bladder Disease	<input type="checkbox"/> Ear - Hearing Loss	<input type="checkbox"/> Stroke		
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Ear - Noise Exposure	<input type="checkbox"/> Trauma - Face		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Ear - Trauma	<input type="checkbox"/> Trauma - Nose		
<input type="checkbox"/> Angina/Heart Attack	_____	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Trauma - Concussion		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Venereal Disease		
<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Vertigo		
<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Headaches		
<input type="checkbox"/> Skin Cancer					
Childhood Illnesses:	<input type="checkbox"/> Usual Childhood Illnesses	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ear Infections		
Current Medications:					
Preferred Pharmacy (with location/Zip Code):					
Allergies: (include reaction)					
Hospitalization/Surgery: (When/Why?)					

USE BACK OF FORM IF NECESSARY Check here if back of form used.