Name:	Date of Birth:	Today's Date:
e-mail address:	Height:	Weight:

PATIENT SOCIAL HISTORY

Present or Past Occupation: □ Retired □ Woodworker?

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Alcohol: □ Yes □ No How many drinks/week? When did you quit?	Tobacco: □ Never □ Cigarettes □ Cigars □ 2nd Hand Smoke □ Chew/Snuff □ Quit, finish below How old were you when you started? & Quit?	Recreational Drugs: □ Never □ Marijuana Other_____
Caffeine: □ Yes □ No How many drinks/week?	How would you rate your lifestyle? □ Active □ Moderate □ Sedentary	

Do you have a living will or Advanced Directive? □ Yes □ No, Where?

FAMILY MEDICAL HISTORY

Has anyone in your immediate family (parents/brothers/sisters) had… □ None of These

□ Alcoholism	□ Cancer: _____	□ Ear - Otosclerosis	□ Kidney Disease
□ Anemia	_____	□ Epilepsy or Seizures	□ Mental Illness
□ Angina (Chest Pain)	□ Diabetes	□ Glaucoma	□ Stroke
□ Arthritis	□ Ear - Hearing Loss	□ Headaches	□Thyroid Problem
□ Allergies/Hay Fever	□ Ear - Deafness	□ Heart Disease	□ Tuberculosis
□ Bleeding Disorder	□ Ear - Meniere's Disease	□ High Blood Pressure	□ Skin Cancer

□ 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… □ None of These

□ AIDS/HIV	□ Bladder Disease	□ Ear - Hearing Loss	□ Stroke
□ Alcoholism	□ Bleeding Disorder	□ Ear - Noise Exposure	□ Trauma - Face
□ Anemia	□ Cancer: _____	□ Ear - Trauma	□ Trauma - Nose
□ Angina/Heart Attack	_____	□ High Blood Pressure	□ Trauma - Concussion
□ Arthritis	□ Diabetes	□ Kidney Disease	□ Tuberculosis
□ Asthma	□ Heart Disease	□ Liver Disease	□ Venereal Disease
□ Thyroid Problem	□ Epilepsy or Seizures	□ Lung Disease	□ Vertigo
□ Allergies/Hay Fever	□ Glaucoma	□ Mental Illness	□ Headaches
			□ Skin Cancer

Childhood Illnesses: □ Usual Childhood Illnesses □ Rheumatic Fever □ 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.