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: _____