Patient Name: **Account No.** **DOB: ____/____/____**

Patient Medical History Form (p. 1): Please provide the following medical information to the best of your ability:

Date:	**Age:**	**List any ALLERGIES TO MEDICATIONS:**
What problems are you here for today?		

Past Medical History:

1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No			Yes	No	
Diabetes	☐	☐		**Stomach or Intestinal problems**	☐	☐	
Hypertension (high blood press)	☐	☐		**Allergy problems/therapy**	☐	☐	
Thyroid problems	☐	☐		**Kidney problems**	☐	☐	
Heart Disease/cholesterol probs	☐	☐		**Neurological problems**	☐	☐	
Respiratory problems	☐	☐		**Cancer**	☐	☐	
Bleeding Disorder	☐	☐		**Other Medical Diagnosis**	☐	☐	

2) Please list any operations (and dates) you have ever had *(including tonsils & adenoids)*:

3) Please list any current medications (and amounts, times per day);
(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):

Social History:	Yes	No	**Please list details below:**
Do you smoke? List how much	☐	☐	
If no, did you smoke previously?	☐	☐	
How often do you drink alcohol?			
What type of alcohol do you prefer?			

How much caffeine do you consume per day? Coffee____cups / Decaf____cups / Tea____cups / Soda____glasses / chocolate____oz.

How much (circle which) mint, cinnamon, &/or ginger do you consume per day? Gum____sticks / Candy____oz / Throat lozenges____loz.

What is your occupation?

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:
If yes, please indicate which relative(s) have the problem

	Yes	No	
Hearing problems	☐	☐	
Allergy	☐	☐	
Cancer	☐	☐	
Bleeding disorder	☐	☐	
Anesthesia problems	☐	☐	

☐ **See attached dictation** **Reviewed by:**

Date____/____/____

Patient Name: **Account No.** **DOB: ____/____/____**

Patient Medical History Form (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:

1) Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:

2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for your visit today

		Yes	No	Current		Yes	No	Current
GENERAL	chills	☐	☐	☐	weight loss or gain	☐	☐	☐
	fatigue	☐	☐	☐	daytime sleepiness	☐	☐	☐
ALLERGY	environmental allergy	☐	☐	☐	sneezing fits	☐	☐	☐
	post-nasal drip	☐	☐	☐				
NEURO	headache	☐	☐	☐	weakness	☐	☐	☐
	passing out	☐	☐	☐	numbness, tingling	☐	☐	☐
EYES	eye pain / pressure	☐	☐	☐	vision changes	☐	☐	☐
	watery or itchy eyes	☐	☐	☐				
ENT	ear pain or itch	☐	☐	☐	ear drainage	☐	☐	☐
	hearing loss	☐	☐	☐	ear noises	☐	☐	☐
	dizziness	☐	☐	☐	lightheadedness	☐	☐	☐
	nasal congestion	☐	☐	☐	sinus pressure or pain	☐	☐	☐
	sense of smell problem	☐	☐	☐	problem snoring, apnea	☐	☐	☐
	hoarseness	☐	☐	☐	throat pain	☐	☐	☐
	throat clearing	☐	☐	☐	throat dryness/itching	☐	☐	☐
RESPIR.	cough	☐	☐	☐	coughing blood	☐	☐	☐
	wheezing	☐	☐	☐	shortness of breath	☐	☐	☐
CARDIAC	chest pain	☐	☐	☐	palpitations	☐	☐	☐
GI	difficulty swallowing	☐	☐	☐	heartburn	☐	☐	☐
	abdominal pain	☐	☐	☐	nausea/vomiting	☐	☐	☐
	bowel irregularity	☐	☐	☐	rectal bleeding	☐	☐	☐
GU	frequent urination	☐	☐	☐	prostate problems	☐	☐	☐
HEME/LYM	swollen glands	☐	☐	☐	sweating at night	☐	☐	☐
	bleeding problems	☐	☐	☐	easy bruising	☐	☐	☐
ENDO	feel warmer than others	☐	☐	☐	feel cooler than others	☐	☐	☐
MSK	joint aches	☐	☐	☐	muscle aches	☐	☐	☐
SKIN	rash	☐	☐	☐	hives	☐	☐	☐
	itching	☐	☐	☐	skin or hair changes	☐	☐	☐

PLEASE STOP HERE ☐ See attached dictation

CURRENT MEDS #130: ☐ QDC G8427: Med list up-to-date as documented in today's note or reviewed from date ____/____/_____

TOBACCO USE #226: ☐ QDC G9906: Patient uses tobacco & was provided cessation intervention - _____

☐ QDC G9903: Patient screend & ID as a non-user

☐ QDC G9907 & G9902: Patient is a user but medical reason why intervention not provided was documented

PNEUMOCOCCAL VACCINE #111: ☐ QDC 4040F: Pneumococcal vaccine previously received

☐ QDC 4040F-8P: Pneumoccocal vaccine not previously received or not admin. Reason NOS

ADVANCED CARE PLAN #47: ☐ QDC 1123F: Adv Care plan discussed & documented, OR surrogate decision maker named _____

☐ QDC 1124F Patient did not want to discuss - Cultural/spiritual beliefs

Reviewed by: