All information provided will be scanned into your electronic medical record. Please complete accurately.

Date_____ Referring Physician_____ Height_____ Weight_____

Name_____ DOB_____ Age_____

MEDICAL HISTORY: (Have you had any of the following conditions?)

Pneumonia	No	Kidney Disease	No
Heart Attack	No	Hearing Loss	No
Liver Failure	No	Hepatitis	No
Jaundice at Birth	No	Heart Murmur	No
Angina	No	Epilepsy/Seizures	No
Heart Failure	No	Migraine Headaches	No
Stroke	No	Arthritis	No
Diabetes	No	Bleeding Disorders	No
Connective Tissue Disease	No	Cancer	No
High Blood Pressure	No	Type of Cancer _____	
Neck: Neuritis or Sciatica	No	Nervous Breakdown or Disorder	No
Enlarged Thyroid/Goiter	No	Asthma	No
Anemia-Chronic/Current	No	Emphysema	No
HIV	No	Enlarged Lymph Glands of Neck	No
		Drug Abuse, Past or Present	No

Any other chronic conditions that are not listed? _____

_____

Please describe any question that was answered **YES** from the above:

_____

_____

FAMILY HISTORY: (Has any ***blood relative*** had any of the following? ☐ Unknown

		Who			Who
Cancer	No	_____	High Blood Pressure	Yes	_____
Tuberculosis	No	_____	Bleeding Problems	No	_____
Diabetes	No	_____	Hearing Loss	No	_____
Heart Trouble	No	_____	Malignant Hyperthermia	No	_____

SOCIAL HISTORY:

Alcoholic Beverages Never☐ Barely☐ Moderate☐ Daily☐

Caffeinated Beverages Never☐ Barely☐ Moderate☐ Daily☐

Tobacco: Cigarettes_____packs per day for ___years; Cigar☐ Pipe☐ Chewing Tobacco☐ Snuff☐

Prior Smoker☐ No ☐ Yes Quit: ☐ Yes ☐ No How long ago? _____

Is the environment in which you work loud or noisy? No
Have you ever been exposed to any loud or unusual noises? No
Are you exposed to chemicals or have you been? No
Have you been in the military? No

CURRENT MEDICATIONS: (List ALL including over the counter, hormones, diet pills etc.)☐ None

_____
_____
_____

ALLERGIES: ☐ None

_____ _____
_____ _____
_____ _____

SURGERIES: (List ALL Surgeries and dates)☐ None

_____ _____
_____ _____
_____ _____
_____ _____

HOSPITALIZATIONS: (not including surgery)☐ None

_____
_____

DIFFICULTIES WITH ANESTHESIA? ☐ No ☐ Yes ☐ Never been under anesthesia

If yes, please explain:

_____