

Summit Medical Group

Welcome To Our Office

PATIENT HEALTH HISTORY

Please print clearly.

Full Name: _____ Date of Birth: _____
(First) (M.I.) (Last)

Weight: _____ lbs. Occupation: _____

Are you taking ANY kind of medication now? This includes prescription medications, over-the-counter medications (such as aspirin), or herbal medications.

No Yes. If yes, please complete the form below.

Please list all prescription, over-the-counter, and herbal medications that you are currently taking.

Medication	Dose (eg, 25 mg)	How often?	Reason for Medication	Date started	Prescribing Doctor

Please check all that apply to you:

	NO	YES		NO	YES
Chest pain			Fever, chills or night sweats		
Palpitations or irregular heartbeat			Fatigue, general weakness, decreased energy		
Swelling of ankles (edema)			Recent change in weight		
Shortness of breath or wheezing			Hoarseness or difficulty speaking		
Persistent cough			Dry mouth or trouble swallowing		
Poor appetite			Sore mouth, bleeding gums, mouth ulcers		
Nausea, vomiting or heartburn			Snoring		
Diarrhea			Nasal congestion		
Constipation			Frequent colds or hay fever		
Urinary infection or blood in your urine			Frequent nosebleeds		
Frequent need to urinate			Bruise easily		
Difficulty emptying your bladder			Blurred or double vision		
Increased thirst			Loss of vision, eye problems		
Skin rash or itching			Depression or severe mood swings		
Raw skin, skin sores or blisters			Nervousness, anxiety or panic attacks		
Headaches			Neck stiffness, neck pain, neck swelling		
Tremors or shaking or convulsions			Joint pains or arthritis		
Numbness, tingling or "pins & needles"			Difficulty walking		
Memory loss			Muscle weakness, cramps or pains		
Fainting or blackouts			Severe pain of any kind		
Dizziness, unsteadiness or vertigo					

Are you allergic to any medications?

No Yes. If yes, please list

Medication _____ Type of reaction (hives, nausea) _____

Are you allergic to pollens, dust, foods, etc.?

No Yes. If yes, please list

Allergen _____ Type of reaction (hives, nausea) _____

Have you ever been diagnosed with a health problem such as diabetes, high blood pressure, heart disease, stroke, asthma, cancer, lupus, etc.

No Yes. If yes, please list below

Have you ever had an operation?

No Yes. If yes, please list surgery and date or age.

Have you ever had a bad reaction to local or general anesthesia?

No Yes. If yes, please list reaction and date or age.

Has anyone in your immediate family had a bad reaction to local or general anesthesia?

No Yes. If yes, list reaction and family member

Have you ever been hospitalized for a medical problem not requiring surgery?

No Yes. If yes, please list reason and date or age

Have you ever had a serious accident or a head injury with loss of consciousness?

No Yes. If yes, please list injury and date or age.

Does anyone in your family have bleeding or blood clotting problems?

No Yes. If yes, please list problem and who has it

Are there any medical problems that run in your family such as diabetes, heart disease, or hearing loss?

No Yes. If yes, please list problem and who has it

Have you ever used tobacco in any form?

No Yes. If yes, please list

Type and daily amount _____ From (year) To (year) _____

Are you exposed to second hand smoke?

No Yes

Do you drink alcoholic beverages?

No Yes. If yes, please list

Type and daily amount _____ From (year) To (year) _____

Have you been exposed to very loud noise repeatedly or for long periods of time?

No Yes. If yes, please list type of noise (construction, machine shop, fire arms, military service, rock concerts) and how many years of exposure

Thank You

Patient signature: _____ Date: _____

FOR OFFICE USE: Reviewed with patient. _____

Summit Medical Group

Referral Information

Patient's Last Name: _____ First name: _____ MI _____

Who referred you to our office?

Physician Friend or Patient Internet Other: _____

Referring Physician This is also my Primary Care Physician

_____ Phone (____) _____
First name Last name

_____ State ZIP
Number and Street Suite No. City

Primary Care Physician (PCP)

_____ Phone (____) _____
First name Last name

_____ State ZIP
Number and Street Suite No. City

Other specialists that you want us to send a report about your visit

_____ Phone (____) _____ Specialty? _____
First name Last name

_____ State ZIP
Number and Street Suite No. City

_____ Phone (____) _____ Specialty? _____
First name Last name

_____ State ZIP
Number and Street Suite No. City

Audiologist or Hearing Aid Dispenser

_____ Phone (____) _____
First name Last name

_____ State ZIP
Number and Street Suite No. City