Summit Medical Group

Welcome To Our Office

PATIENT HEALTH HISTORY

Please print clearly.

Full Name: ________________ (First) ____ (M.I.) __________________________ (Last) Date of Birth: ______________

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.

0 No 0 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					
Palpitations or irregular heartbeat			Fever, chills or night sweats		
Swelling of ankles (edema)			Fatigue, general weakness, decreased energy		
Shortness of breath or wheezing			Recent change in weight		
Persistent cough			Hoarseness or difficulty speaking		
Poor appetite			Dry mouth or trouble swallowing		
Nausea, vomiting or heartburn			Sore mouth, bleeding gums, mouth ulcers		
Diarrhea			Snoring		
Constipation			Nasal congestion		
Urinary infection or blood in your urine			Frequent colds or hay fever		
Frequent need to urinate			Frequent nosebleeds		
Difficulty emptying your bladder			Bruise easily		
Increased thirst			Blurred or double vision		
Skin rash or itching			Loss of vision, eye problems		
Raw skin, skin sores or blisters			Depression or severe mood swings		
Headaches			Nervousness, anxiety or panic attacks		
Tremors or shaking or convulsions			Neck stiffness, neck pain, neck swelling		
Numbness, tingling or "pins & needles"			Joint pains or arthritis		
Memory loss			Difficulty walking		
Fainting or blackouts			Muscle weakness, cramps or pains		
Dizziness, unsteadiness or vertigo			Severe pain of any kind		

Are you allergic to any medications?

0 No 0 Yes. If yes, please list

Medication	Type of reaction (hives, nausea)

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

0 No 0 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.

0 No 0 Yes. If yes, please list below

Have you ever had an operation?

0 No 0 Yes. If yes, please list surgery and date or age.

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

0 No 0 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?

0 No 0 Yes. If yes, list reaction and family member

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

0 No 0 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?

0 No 0 Yes. If yes, please list injury and date or age.

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

0 No 0 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?

0 No 0 Yes. If yes, please list problem and who has it

Have you ever used tobacco in any form?

0 No 0 Yes. If yes, please list

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

Are you exposed to second hand smoke?

0 No 0 Yes

Do you drink alcoholic beverages?

0 No 0 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?

0 No 0 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

____
Number and Street Suite No. City State ZIP

Primary Care Physician (PCP)

______________________ Phone (____) ____________
First name Last name

____
Number and Street Suite No. City State ZIP

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

______________________ Phone (____) __________ Specialty? ____________
First name Last name

____
Number and Street Suite No. City State ZIP

______________________ Phone (____) __________ Specialty? ____________
First name Last name

____
Number and Street Suite No. City State ZIP

Audiologist or Hearing Aid Dispenser

______________________ Phone (____) ____________
First name Last name

____
Number and Street Suite No. City State ZIP