PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION TO THE BEST OF YOUR ABILITY:

Patient's Name:____Date of Birth:______________Age:_____
Occupation:______________________________If retired, what was your occupation__________________
Height:____________________________ Weight____________________
Do you wear hearing aids? No___ Yes___ Which side? Right side____ Left side____ Both sides____
What problem are you here for today?____

____
How long have you had these symptoms?____
Are you allergic to any medications? No____ Yes____. If yes, please list medications:___________________

____

PERSONAL MEDICAL PAST HISTORY: Please circle Yes or No to indicate if you have had any of the following illnesses. If yes, please explain:

Diabetes…………………. No Yes ______________________
High blood pressure…… No Yes ______________________
Thyroid problems………No Yes ______________________
Heart disease……………No Yes ______________________
Cholesterol problems….. No Yes ______________________
Respiratory problems…. No Yes ______________________
Stomach problems……...No Yes ______________________
Intestinal problems……. No Yes ______________________
Allergy problem/therapy.No Yes ______________________
Kidney problems………. No Yes ______________________
Neurological problems…No Yes ______________________
Cancer………………….. No Yes ______________________
Other medical diagnosis..No Yes ______________________
**Exposure to Covid 19? No Yes if tested positive, date of test____/_____/_____
Please list any & all of the operations and dates:_______________________________________

____

____

Please list all hospitalization dates & conditions:_______________________________________

____

____

Please list any current medications (include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays, etc.). Please include strength and dosage.+You may also provide a prewritten list of your medications if available.

____

____

Have you had flu shot? Yes (when___/___/___) No
Have you had pneumonia shot? Yes (when___/___/___) No

SOCIAL HISTORY:

Have you used tobacco in any form? No Yes if yes, cigarettes cigars chewing tobacco
How many packs a day? ___________ How many years?_________ If quit, date you quit_________________
Have you been exposed to second hand smoke? No Yes If yes, explain___________________________

____
How often do you drink alcohol?____
What type of alcohol do you prefer?____
Female Only: are you pregnant? No Yes if yes, what trimester?___________________________

FAMILY HISTORY: Please circle Yes or No to indicate whether any blood relatives have had any of the following illness, If yes, please indicate which relative(s) have the problem:

Hearing problems………No Yes ______________________
Allergy………………….No Yes ______________________
Diabetes………………...No Yes ______________________
Cancer………………….. No Yes ______________________
Bleeding disorder……… No Yes ______________________
Anesthesia problems…... No Yes ______________________
Heart problems…………No Yes ______________________
Smoking………………...No Yes ______________________

CONTINUE ON REVERSE SIDE (TURN PAGE OVER) ---------------------

Patient's Name:____

MEDICAL HISTORY FORM (PAGE 2)

PAST MEDICAL HISTORY: Please circle "YES" or "NO" to indicate whether you presently have any of the following symptoms. For a "YES" answer, please indicate "CURRENT" if this symptom relates to the reason for your visit today.

ALLERGY:

Sneezing	No	Yes	Current
Environmental allergy	No	Yes	Current
Postnasal drip	No	Yes	Current

ENT:

Ear pain	No	Yes	Current
Ear itching	No	Yes	Current
Hearing loss	No	Yes	Current
Dizziness	No	Yes	Current
Nasal congestion	No	Yes	Current
Sense of smell problem	No	Yes	Current
Hoarseness	No	Yes	Current
Throat clearing	No	Yes	Current
Ear drainage	No	Yes	Current
Ear noises	No	Yes	Current
Lightheadedness	No	Yes	Current
Sinus pressure/pain	No	Yes	Current
Snoring/apnea	No	Yes	Current
Throat pain	No	Yes	Current
Throat dryness	No	Yes	Current
Throat itching	No	Yes	Current

HEME/LYM:

Swollen glands	No	Yes	Current
Bleeding problems	No	Yes	Current
Sweating at night	No	Yes	Current
Easy bruising	No	Yes	Current

GU:

Frequent urination	No	Yes	Current
Painful urination	No	Yes	Current

PSYCH:

Depression	No	Yes	Current
Anxiety or panic	No	Yes	Current

MSK:

Joint aches	No	Yes	Current
Muscle aches	No	Yes	Current

RESP:

Cough	No	Yes	Current
Wheezing	No	Yes	Current
Coughing blood	No	Yes	Current
Shortness of breath	No	Yes	Current

EYES:

Eye pain	No	Yes	Current
Watery/itchy eyes	No	Yes	Current

GI:

Difficulty swallowing	No	Yes	Current
Heartburn	No	Yes	Current

NEURO:

Headache	No	Yes	Current
Passing out	No	Yes	Current
Weakness	No	Yes	Current
Numbness/tingling	No	Yes	Current

GENERAL:

Chills	No	Yes	Current
Fatigue	No	Yes	Current
Weight loss	No	Yes	Current
Weight gain	No	Yes	Current
Daytime sleepiness	No	Yes	Current

ENDO:

Feel warmer than others	No	Yes	Current
Feel cooler than others	No	Yes	Current

CARDIAC:

Chest pain	No	Yes	Current
Palpitations	No	Yes	Current

SKIN:

Rash	No	Yes	Current
Itching	No	Yes	Current
Hives	No	Yes	Current
Skin changes	No	Yes	Current
Hair changes	No	Yes	Current

DO YOU HAVE FOLLOWING SYMPTOMS (circle if yes) FEVER COUGH SHORTNESS OF BREATH

HAVE YOU BEEN IN CONTACT WITH SOMEONE WITH CONFIRMED COVID-19 WITHIN PAST 2 WEEKS? YES NO

HAVE YOU OR ANYONE YOU HAVE HAD CLOSE CONTACT WITH TRAVELLED INTERNATIONALLY IN LAST 2 WEEKS? YES NO EXPLAIN IF ANSWERED YES______________________________
____

What is the name of your family doctor?______________________________

What doctor referred you to this office?______________________________

Did a patient refer you to Dr. Kardos? If so, indicate name of patient______________________________

AFTER BOTH SIDES OF THIS FORM HAVE BEEN COMPLETED, PLEASE SIGN YOUR NAME BELOW

____
Patient's signature

____
Today's date

Reviewed by:______________________________

REVISED 4/22/2020