Wichita Ear Clinic
PATIENT HEALTH HISTORY

Patient Name: _____ Preferred Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Health Maintenance:

Influenza (flu)	☐ Yes	☐ No	When: _____
Pneumococcal (pneumonia)	☐ Yes	☐ No	When: _____
Colonoscopy	☐ Yes	☐ No	When: _____
Mammogram (females 50-74)	☐ Yes	☐ No	When: _____
Any Falls within the last year	☐ Yes	☐ No	How many? _____
Tobacco Use	☐ Yes	☐ No	
Anesthesia Complications	☐ Yes	☐ No	Explain: _____

Tests:

CT SCAN or MRI of head/brain (Circle one) When: _____ Where: _____

SURGICAL HISTORY (EAR SURGERIES ONLY)

Procedure	Date Performed	Performing Doctor
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

SURGICAL HISTORY (EXCLUDING EAR SURGERIES)

1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____

MEDICATION ALLERGIES Drug	**Type of Reaction**
1._____	_____
2._____	_____
3._____	_____

ALL MEDICATIONS

Including over the counter	Dosage (mg)	How many per day
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____

Pharmacy Preference (include location): _____