Wichita Ear Clinic
PATIENT HEALTH HISTORY

Patient's Last Name _____ **First** _____ **MI** _____

Preferred Name _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

CT SCAN ☐ **(or) MRI of head/brain** ☐ (check one) When: _____ Where: _____

VACCINATIONS: Pneumococcal Vaccine (pneumonia) ☐ Yes ☐ No If yes, when: _____

SURGERIES AND HOSPITALIZATIONS.
Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No
If yes, please list type of problems: _____

SURGICAL HISTORY (EAR SURGERIES ONLY)

Procedure	**Date Performed**	**Performing Doctor**
1.		
2.		

SURGICAL HISTORY (EXCLUDING EAR SURGERIES)

1		
2		
3		
4		
5		
6		

MEDICATION ALLERGIES Drug	**Type of Reaction**
1.	
2.	
3.	
4.	
5.	

ALL MEDICATIONS

Including over the counter	**Dosage (mg)**	**How many per day**
1.		
2.		
3.		
4.		
5		
6		
7		
8		

Pharmacy Preference (include location): _____

I give consent to Wichita Ear Clinic to obtain my Prescription History (prescriptions taken in the past) from my health plan or pharmacy.

☐ Yes ☐ No

_____ _____

Patient Signature **Date**