|  |  |
| --- | --- |
| **CLEAR LAKE MEDICAL CENTER ENT****Daily Medication Record** |  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **List current medications and dosage:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Drug Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PAST MEDICAL HISTORY** |
| * Asthma/COPD
* Atrial Fib/Flutter
* Cancer (list type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Depression
* NO CHANGES
 | * Anxiety
* Diabetes
* Gastric Reflux
* Heart Disease/MI
* High Cholesterol
 | * High Blood Pressure
* Kidney Disease
* Migraines
* Seizures
 | * Sleep Apnea
* Stomach Ulcers
* Stroke
* Thyroid Disease
* Other: \_\_\_\_\_\_\_\_
 |
| **PAST SURGICAL HISTORY** |
| * Ear Tubes
* Neck Surgery (i.e. thyroid)
* Septum Surgery
* NO CHANGES
 | * Sinus Surgery
* Tonsillectomy
* Adenoidectomy
 | * Vocal Cord Surgery
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **FAMILY MEDICAL HISTORY**(Please list which relative, if any, has the following conditions) |
| * Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Heart Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* NO CHANGES
 | * High Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Stroke: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **ALCOHOL USAGE** | **TOBACCO USAGE** |
| * Never
* Less than monthly
* Monthly
 | * Weekly
* Daily
 | * Never
* Former:

Years of Usage: \_\_\_\_\_\_ | * Current User:

Packs per day: \_\_\_\_\_\_\_Years of Usage: \_\_\_\_\_\_ |
| When was your last Flu Shot? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When was your last Pneumococcal Vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PHARMACY****INFORMATION:** | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cross Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Printed Name Date of Birth