|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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Signature Printed Name Date of Birth