Greater Philadelphia Ear Specialists, P.C.

Medical History and Demographic Information

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____

Cell Phone: _____ Home Phone: _____ Primary Language_____

Email Address: _____

Referring Doctor Name: _____ Phone: _____

Primary Doctor Name: _____ Phone: _____

Primary Pharmacy Name: _____ Phone: _____

Medical Insurance Information

(Please bring your health insurance cards and photo ID to your appointment)

Primary Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Policy Holder/Subscriber Name: _____

Policy Holder/Subscriber Date of Birth: _____ Relationship to Policy Holder: _____

Secondary Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Policy Holder/Subscriber Name: _____

Policy Holder/Subscriber Date of Birth: _____ Relationship to Policy Holder: _____

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Allergies

Do you have any medication allergies? ☐Yes ☐ No
If yes, please list all medication allergies: _____

_____

Current Medications

If you are not taking any medications, please check this box ☐

List all medications you are taking:

Drug Name	Dosage	Frequency/How it is Taken

Medical History

If you do not have any current or past medical conditions, please check this box ☐

Do you have, or have you ever had…?

- ☐ Heart Disease (heart attack, angina, heart surgery, arrhythmia)
- ☐ Diabetes
- ☐ Lung Disease (Asthma, COPD, emphysema, etc.)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypothyroidism (Underactive Thyroid)
- ☐ Hyperthyroidism (Overactive Thyroid)
- ☐ Kidney Problems
- ☐ Cancer
- ☐ Liver Disease
- ☐ Head Trauma
- ☐ Stroke or TIA
- ☐ Migraine Headaches
- ☐ Seizure
- ☐ Anxiety Disorder
- ☐ Depression

- ☐ Panic Attacks
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Bleeding Disorder (Hemophilia, Platelet Disorder, etc.)
- ☐ Other: _____

Family History

Have any immediate family members had any of the following medical problems…?
(Include relationship to you (i.e. Mother, Father, Sister, Brother, Daughter, Son)

☐ Epilepsy (Seizures) _____
☐ Heart Disease _____
☐ Migraine _____
☐ Stroke _____
☐ Mental Illness _____
☐ High Blood Pressure _____
☐ Bleeding Disorder _____
☐ Diabetes _____
☐ Cancer _____
☐ Thyroid Problems _____
☐ Hearing Loss _____
☐ Anemia _____
☐ Glaucoma _____

Social History

Do you smoke? ☐ Yes ☐ No
How many… Per day: _____ Per week: _____

Former Smoker? ☐ Yes ☐ No *If yes*, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks… Per day: _____ Per week: _____

Surgical History

Have you had surgery in the past? ☐ Yes ☐ No

If yes, please list prior procedures: _____

_____

_____

Have you ever had a complication with anesthesia? ☐ Yes ☐ No

If yes, please explain: _____