PLEASE PROVIDE US WITH YOUR PHARMACY'S NAME AND PH#

Last Name: **First Name:** **DOB:**

Name of Physician who referred you:

Reason for your visit today?

How long have you had this problem?

Do you have any medical conditions we should be aware of ?

Do you have Hearing Loss?		***Do you wear Hearing Aids?***	
Date of last hearing test?		***Would you like a hearing test?***	

Have you ever been diagnosed with the following? Please circle Yes or No

Skin Lesions	*YES*	*NO*	**COPD**	*YES*
Headache/Migraine	*YES*	*NO*	**Arthritis**	*YES*
Seasonal Allergies	*YES*	*NO*	**Thyroid**	*YES*
Asthma	*YES*	*NO*	**Diabetes**	*YES*
Stroke	*YES*	*NO*	**Cancer TYPE?**	*YES*
Angina	*YES*	*NO*	**Immunizations up to date?**	*YES*
Heart Attack	*YES*	*NO*	**Vision Problems**	*YES*
High Blood Pressure	*YES*	*NO*	**Depression**	*YES*
Reflux Disease	*YES*	*NO*	**Kidney disease/stones**	*YES*

If you answered yes to any of the above please explain:

List type and date of all surgeries you have had:

Please list your current medications including over the counter remedies

****ARE YOU ALLERGIC TO ANY MEDICATIONS?***	

Height **Weight**

Tobacco Use: Y/N **How many packs per day?** **How long?** **When did you quit?**

Do you consume Alcohol? Y/N **How many drinks per day?** **How long?**

By signing below I agree that all the above information I have provided is true and accurate,

Patient Signature: **Date:**

Guardian if patient is a minor: **Date:**

NO
NO
NO
NO
NO
NO
NO
NO
NO