CLEAR LAKE MEDICAL CENTER ENT
Daily Medication Record

List current medications and dosage: _____
_____
_____
_____

Drug Allergies: _____
_____

PAST MEDICAL HISTORY
(Please check all that apply)

- ☐ Asthma/COPD
- ☐ Atrial Fib/Flutter
- ☐ Cancer (list type): _____
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Gastric Reflux
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ 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
- ☐ 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: _____
- ☐ High Blood Pressure: _____
- ☐ Stroke: _____
- ☐ Other: _____

ALCOHOL USAGE

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily

TOBACCO USAGE

- ☐ Never
- ☐ Former:
  Year Quit: _____
  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: _____

May we contact your pharmacy to request a list of your current medications? ☐ Yes ☐ No

_____

Signature Printed Name Date