CAS D6 3/1/19

Community Audiology Services, LLC

MEDICATION & GENERAL HEALTH HISTORY

Name:_____

Print Name Today's Date

Your complete medication and general health history are important. Please fill out this form completely. If for some reason you are unable to complete this form today, please update it at your next appointment.

1. ALLERGIES Are you allergic to medication(s), iodine, food, tape, or latex?

Allergy	Reaction	Allergy	Reaction

2. CURRENT MEDICATION(S)
Please list all prescription and non-prescription medication, herbals, eye drops, nutritional supplements, and inhalers, etc. that you currently use.

Name of Medicine	Dose	Directions	Purpose

3. GENERAL HEALTH HISTORY Please check ALL that apply.

☐ Alcohol Dependence	☐ High Blood Pressure	☐ Eye/vision problems/loss	☐ Liver Disease	☐ Neurological /Disorder	☐ Smoker
☐ Allergies	☐ Whiplash	☐ Genetic Disorders	☐ Loud Noise Exposure	☐ Organic Solvent Exposure	☐ Stroke
☐ Alzheimer's Disease	☐ Chemotherapy	☐ Heart Disease	☐ Measles	☐ Otosclerosis	☐ Syphilis
☐ Arthritis	☐ High Cholesterol	☐ Heavy Metal Exposure	☐ Meniere's Disease	☐ Parkinson's Disease	☐ Mumps
☐ Atherosclerosis	☐ Chronic Ear Infection	☐ Head Trauma	☐ Meningitis	☐ Radiation Therapy	
☐ Autoimmune Disease	☐ Concussion	☐ Iron Deficiency	☐ Tuberculosis	☐ Seizure	
☐ Blood Disease	☐ Diabetes	☐ Kidney Disease	☐ Multiple Sclerosis	☐ Skull Fracture	

4. ADDITIONAL INFORMATION Please use this space to tell us more about your medication(s)/general history.

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