SHOHET EAR ASSOCIATES
MEDICAL GROUP, INC.

Annual Patient Update

Patient Name:_____

Primary Care Physician:_____

Referring Physician/Source:_____

Pharmacy:_____City/State:_____Cross Street:_____

Patient Height:_____Weight:_____

Pain Level 1-10 (10 being most severe):_____

Smoking: ☐ Current ☐ Former ☐ Never

History of falling for any reason? ☐ Yes ☐ No
If yes, explain:_____

Have you received the following vaccines?
Prevnar vaccine (PCV13) ☐ Yes ☐ No Date received:_____
Pneumovax vaccine (PPSV23) ☐ Yes ☐ No Date received:_____
Tetanus vaccine ☐ Yes ☐ No Date received:_____
Flu vaccine ☐ Yes ☐ No Date received:_____

Current Allergies No Allergies ☐
Allergy:_____Reaction:_____

Allergy:_____Reaction:_____

Allergy:_____Reaction:_____

MEDICATIONS (List current medications OR attach list) ☐ No Medications

Drug Name	Dosage	Frequency	**Status:** Chronic, Acute, Discontinued