

Today's Date \_\_\_\_\_

Last Name    First Name    Middle Initial                      Age                      Date of Birth

Occupation                                      Male                      Female

Chief Complaint      What Symptoms are you having that brings you to visit this doctor.

\_\_\_\_\_

Medications      List below the medications you are taking. Include prescriptions, and other medicines such as aspirin, vitamins, cold medicines, etc.

Name	Amount	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:      Are you allergic to any medications?    Yes                      No

If so, which ones: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History of Present Illness:      Describe the details of your present problem.

	Rt Ear	Lt Ear	Duration
Hearing Loss	_____	_____	_____
Fluctuating Hearing	_____	_____	_____
Ear Fullness	_____	_____	_____
Ringing/Tinnitus	_____	_____	_____
Ear Infection	_____	_____	_____
Better Hearing Ear	_____	_____	_____
Hearing Aid	_____	_____	_____
Ear Pain	_____	_____	_____
Facial Weakness	_____	_____	_____
Facial Spasms	_____	_____	_____
Noise Exposure	_____	_____	_____
Location: Work, Home, Recreational		Noise Protection?	Yes                      No

Do you have dizziness?                      Yes                      No  
 When did it begin? \_\_\_\_\_  
 How long does it last? \_\_\_\_\_  
 How often does it happen? \_\_\_\_\_  
 Is your dizziness      Mild \_\_\_\_\_      Moderate \_\_\_\_\_      Severe \_\_\_\_\_  
 Does your dizziness effect your work?    Yes \_\_\_\_\_      No \_\_\_\_\_  
 Does your dizziness effect your driving? Yes \_\_\_\_\_      No \_\_\_\_\_

Describe your Dizziness:  
 Spinning/Vertigo                      Yes      No                      Positional                      Yes      No  
 Lightheadedness                      Yes      No                      Nausea                      Yes      No  
 Off Balance                      Yes      No                      Headache                      Yes      No

Do you have problems with:  
 Numbness on the face                      Yes      No  
 Double Vision                      Yes      No  
 Blurred Vision                      Yes      No  
 Difficulty Swallowing                      Yes      No  
 Hoarseness                      Yes      No  
 Tongue Weakness                      Yes      No  
 Shoulder Weakness                      Yes      No

Review of Systems: Have you ever been treated for any of the following illnesses?

Fatigue	_____	Ulcer	_____	Thyroid Problems	_____
Fever	_____	Blood in Stool	_____	Pituitary Problems	_____
Weight Loss	_____	Colitis	_____	Bleeding Disorder	_____
Snoring	_____	Prostate Problems	_____	Anemia	_____
Hoarseness	_____	Kidney Stones	_____	Lymphoma	_____
Glaucoma	_____	Hepatitis	_____	Venereal Disease	_____
Double Vision	_____	Liver Trouble	_____	AIDS/HIV	_____
Other Eye Problems	_____	Gall Bladder Problem	_____	Cancer (type?)	_____
Loss of Taste	_____	Kidney Infection	_____	Blood Transfusion	_____
Loss of Smell	_____	Blood in Urine	_____	Seizures	_____
Sinus Trouble	_____	Bladder Infection	_____	Loss of Consciousness	_____
Difficulty Swallowing	_____	Arthritis	_____	Head Injury/Concussion	_____
High Blood Pressure	_____	Fibromyalgia	_____	Multiple Sclerosis	_____
Heart Failure	_____	Bone Disease	_____	Nervous Disorder	_____
Chest Pain/Angina	_____	Joint Disease	_____	Anxiety	_____
Heart Attack	_____	Back Problems	_____	Depression	_____
Ankle/Foot Swelling	_____	Breast (lump/tumor)	_____	Frequent Infections	_____
Shortness of Breath	_____	Rashes	_____	Environmental Allergy	_____
High Cholesterol	_____	Eczema	_____	Hay Fever	_____
Cough	_____	Headaches	_____	Reflux	_____
Diabetes	_____	Meningitis	_____	Sleep Apnea	_____

Please add details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Past Medical History**

Have you had any serious injury? Yes No

---

Have you ever had ear surgery? Yes No  
If yes, what type?

---

Have you ever had any other type of surgery? Yes No  
If yes, what type?

---

Do you have any major illnesses? Yes No  
Please explain:

---

**Family History:** What medical problems run in your family?

Father: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Other: \_\_\_\_\_

**Social History:**

Do you smoke? Yes No How many cigarettes per day? \_\_\_\_\_  
Do you drink alcohol? Yes No How many drinks per day? \_\_\_\_\_  
Have you had problems with alcoholism? Yes No  
Have you had problems with drug use? Yes No  
Do you drink caffeine Yes No

Physician Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I acknowledge that the information stated above is true and complete:

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewing Physician Signature

\_\_\_\_\_  
Date