

Ear Consultants of Georgia Medical History Information

Patient Name _____ Date _____

Birthdate _____

Reason for Visit today _____

Current Medications: _____

Are you **allergic** to any medications? If so, please list. _____

Please list any childhood illnesses. _____

Medical Illnesses: (please check the following)

Asthma _____	Cancer _____	If yes, what type? _____
Clotting Disorder _____	Hepatitis _____	
Diabetes _____	Seizures _____	
Heart Disease _____	Stroke _____	
High Blood Press. _____	Tuberculosis _____	
HIV _____	Other (please list): _____	

Ear History: (please check what applies)

	<u>Right</u>	<u>Left</u>		<u>Right</u>	<u>Left</u>
Hearing Loss	_____	_____	Ear Pain	_____	_____
Tinnitus (head noises)	_____	_____	Pressure	_____	_____
Infection	_____	_____	Hearing Aid	_____	_____

Vertigo _____ Yes _____ No

Dizziness/imbalance _____ Yes _____ No

Ear Surgery _____ Yes _____ No

Please list below type of ear surgery and dates.

Please list any other surgery and dates: _____

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Review of Systems: (please circle any symptoms that you have had **recently** or are currently experiencing)

Constitutional: severe fatigue fever chills loss of appetite unexplained weight loss or weight gain night sweats

HEENT: blurred vision blindness double vision nosebleeds loss of smell sore throat hoarseness

Cardiac: chest pain palpitations passing out heart murmur swelling in hands or feet

Pulmonary: shortness of breath cough wheezing coughing blood or phlegm

Gastrointest.: abdominal pain nausea vomiting heartburn constipation diarrhea dark tarry stool or blood in stool

Urinary: pain or burning on urination blood in urine frequency or urgency uncontrollable

Neurological: severe headaches loss of coordination numbness or tingling paralysis

Endocrine: hair loss thinning or thickened hair or skin excessive thirst frequently cold or hot

Hematologic: easy bruising bleeding gums persistent bleeding with minor cuts

Height: _____ Weight: _____

Social History: (please circle all that apply)

Do you drink alcohol?	Yes	No	If yes, how much?	_____
Do you smoke?	Yes	No	If yes, how much?	_____
Quit smoking?	Yes	No	If yes, how long smoked?	_____ how much? _____
Chew Tobacco?	Yes	No	If yes, how often?	_____
Recreational drugs?	Yes	No	If yes, what and how often?	_____

Family History: (please check all that apply)

	Family member with disorder:				
	<u>Mother</u>	<u>father</u>	<u>sibling</u>	<u>other</u>	
Asthma	_____	_____	_____	_____	specify:
Clotting disorder	_____	_____	_____	_____	
Diabetes	_____	_____	_____	_____	
Glomus tumor in ear or neck	_____	_____	_____	_____	
Heart Disease	_____	_____	_____	_____	
High Blood Pressure	_____	_____	_____	_____	
HIV	_____	_____	_____	_____	
Cancer	_____	_____	_____	_____	
Malignant Hyperthermia	_____	_____	_____	_____	
Seizure disorder	_____	_____	_____	_____	
Stroke	_____	_____	_____	_____	
Thyroid tumors	_____	_____	_____	_____	
Tuberculosis	_____	_____	_____	_____	
Other (please specify):	_____				