



Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Reason for today's visit (Must complete):**

Doctor who referred you for a consultation: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Please, ONLY list if you have been evaluated by this doctor)

Family Doctor/Internist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other doctor involved in your care: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Drug Allergies:**

**Past Medical History: Please list any prior major illnesses/injuries:**

Previous Ear Surgeries:	Side	Year

Other Surgeries:	Year	Complications?

Patient name: \_\_\_\_\_

Age: \_\_\_\_\_

<b>Current Medications:</b>	<b>Dose</b>	<b>Frequency</b>

<b>Family Member</b>	<b>Alive-Deceased</b>	<b>Age</b>	<b>Health Status or Cause of Death</b>
Father			
Mother			
Sister/Brother			
Sister/Brother			
Sister/Brother			

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_

Marital Status:    Single        Married        Divorced        Widowed

Do you have children?    Yes    No    How many? \_\_\_\_\_

Do you live alone?    Yes    No    Who lives with you? \_\_\_\_\_

How much caffeine do you drink per day?    Coffee \_\_\_\_\_    Soda pop \_\_\_\_\_    Chocolate \_\_\_\_\_

How much salt do you eat?    Low salt diet \_\_\_\_\_    No added salt \_\_\_\_\_    Regular intake \_\_\_\_\_

Do you smoke?    ( ) Yes    ( ) No    Packs per day \_\_\_\_\_

Do you drink alcohol?    ( ) Yes    ( ) No    Quantity \_\_\_\_\_

Do you take any street drugs?    ( ) Yes    ( ) No    \_\_\_\_\_

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)?    No    Yes

**Please Explain:**

Patient name: \_\_\_\_\_

Age: \_\_\_\_\_

**REVIEW OF SYSTEMS**

<b><u>Ears</u></b>	<b>Left</b>	<b>Right</b>	<b>Both</b>	<b>Began when?</b>
Hearing loss	_____	_____	_____	_____
Ear pain	_____	_____	_____	_____
Ear drainage	_____	_____	_____	_____
Ringings/noise	_____	_____	_____	_____
Hearing aid?	_____	_____	_____	_____

Who is your hearing aid dispenser? \_\_\_\_\_

**Noise Exposure**

Military	Yes	No	Power tools	Yes	No
Hunting	Yes	No	Chain saws	Yes	No
Firing range	Yes	No	Snowmobiles	Yes	No
Trap shooting	Yes	No	Motorcycle	Yes	No
			Small engines	Yes	No

Occupational (describe): \_\_\_\_\_

**Eyes**

Wear Glasses – Date of last exam: \_\_\_\_\_ Yes No

Visual changes: \_\_\_\_\_ Yes No

Glaucoma Yes No

Cataracts Yes No

**Nose**

Nasal congestion Yes No

Nasal drainage Yes No

Sinus problems Yes No

Environmental allergies Yes No

**Endocrine**

Diabetes Yes No

Thyroid disease Yes No

Hormone problems Yes No

Fever Yes No

Weight loss/gain Yes No

Excessive fatigue Yes No

Date of last thyroid test: \_\_\_\_\_

**Psychiatric**

Anxiety Yes No

Depression Yes No

Other: \_\_\_\_\_

**Neurological**

**Describe:**

Previous head injury	Yes	No	_____
Headaches/Migraine History	Yes	No	_____
Fainting/blackouts	Yes	No	_____
Seizures	Yes	No:	_____
Spinning	Yes	No	_____
Swimming sensation	Yes	No	_____
Loss of balance	Yes	No	_____

Patient name: \_\_\_\_\_

Age: \_\_\_\_\_

**Neurological** (con't)

**Describe:**

Falls	Yes	No	_____
Veering to side	Yes	No	_____
Difficulty with speech/ swallowing	Yes	No	_____
Numbness/weakness of arms/legs	Yes	No	_____
Facial weakness	Yes	No	_____
Neck problems	Yes	No	_____

**Cardiovascular**

**Respiratory**

Chest pain or angina	Yes	No	Asthma	Yes	No
High blood pressure	Yes	No	Chronic cough	Yes	No
Irregular Pulse	Yes	No	Emphysema	Yes	No
Heart Murmur	Yes	No	Shortness of breath	Yes	No
High Cholesterol	Yes	No	Bronchitis	Yes	No
Swelling in feet or hands	Yes	No	Pneumonia	Yes	No
Leg pain while walking	Yes	No	Tuberculosis	Yes	No

**Gastrointestinal**

**Genitourinary**

Indigestion	Yes	No	Urinary tract infections	Yes	No
Nausea	Yes	No	Painful urination	Yes	No
Vomiting	Yes	No	Blood in your urine	Yes	No
Liver Disease/Hepatitis	Yes	No	Incontinence	Yes	No
Abdominal Pain	Yes	No	Difficulty starting or stopping stream	Yes	No
Change in bowel habits	Yes	No			
Ulcers or gastritis	Yes	No			

The above information is accurate to the best of my knowledge.

\_\_\_\_\_  
*Patient signature*

\_\_\_\_\_  
*Date*

I have reviewed the above information with the patient.

\_\_\_\_\_  
*Physician name (printed) & Signature*

\_\_\_\_\_  
*Date*