Patient Age: ___________

Please answer all of the following questions to the best of your ability.
Please write N/A if the question is NOT applicable to you.

CHIEF COMPLAINT:
What is the reason for this appointment?

HISTORY OF PRESENT ILLNESS:
Which of the following symptoms do you suffer?

- Hearing loss
- Dizziness
- Drainage from ear
- Vision problems
- Ear pain
- Ringing in ears
- Headache
- Sinus symptoms

When did the problem(s) start?

Does anything make it better or worse?

Any other associated symptoms?

Have you been tested for allergies?  No Yes  When:_______  Results:____________

PAST MEDICAL HISTORY:
List the medicines you are taking:
1. _______________________
2. _______________________
3. _______________________
4. _______________________
5. _______________________
6. _______________________
List medical conditions you are/have been treated for (high blood pressure, diabetes, etc.)

List previous ear surgeries:

List (other) previous surgeries:

List drug allergies:

If you have had a CT or MRI, where was it performed?

Do YOU have any of the following:

- Asthma/Lung disease
- Heartburn/Reflux
- Arthritis
- Kidney disease
- Diabetes
- Migraines
- Excessive bleeding
- Seizures
- Fevers
- Depression
- Heart Disease
- Stroke

If YES please describe:______________________________________________

SOCIAL HISTORY:
Your occupation:

Do you smoke/chew tobacco?  No Yes  How much:________

Do you drink alcohol?  No Yes  How much:________

FAMILY HISTORY:
Diseases that run in your family:____________________________________

REFERRAL:
Who referred you to the office today?___________  Their address:______________