Medical History Form v.10.12 – Adult
The Ear Center of Greensboro, P.A., 1126 N. Church St., #201, Greensboro, NC 27401
Please fill in the blank or circle the answer where appropriate:

Patient Name:_____ Age_____Gender: M or F Date_____
CC: What problem are you here to have evaluated? _____
_____
HPI: Where is the problem?_____
Describe the problem_____Left\Right
How long have you had the problem?_____How long does it last?_____
How severe is the problem?_____
When do you experience the problem? _____
What situations are likely to bring on the problem?_____
What seems to change your symptoms? _____
What other symptoms or signs occur with the problem?_____

PMH: What serious illnesses or injuries have you had? _____
What surgery have you had? _____
What medications do you take now? Please give dose _____
_____
Are you allergic to any medications? List all: _____
_____
Family History: Are there any inherited diseases that occur in your family such as diabetes, heart disease, problems with anesthesia, excessive bleeding, hearing loss?_____
_____None _____
Social History: (Circle) Married/Single, Job: _____Education: _____
Noise Exposure _____ Do you smoke/use tobacco? Yes/No How much?_____
Do you use alcohol? Yes/No How often? _____
Have you used illegal drugs Yes/No Have you been exposed to HIV? Yes/No
Ethnicity (circle): Non-Hispanic, Hispanic, Not Specfied Race: _____
Preferred Language: English, Spanish, Other: _____

Review of Medical Systems: Have you had any diseases that involve the following areas?
(Circle diseases, write any other problems in blanks, or check if normal).

	Normal
Constitutional: Fever, weight loss, night sweats, _____	_____
Eyes: Loss of vision, cataracts, glaucoma _____	_____
Ears, Nose, Throat: _____	_____
_____	
Cardiovascular: High blood pressure, chest pain, heart attack, irregular pulse, circulation problems	
_____	_____
Respiratory: Asthma, emphysema, chronic bronchitis _____	_____
Gastrointestinal: Reflux, ulcers, liver disease, nausea _____	_____
Musculoskeletal: Arthritis, osteoporosis, fibromyalgia _____	_____
Skin/Breast: Dermatitis, skin cancer, breast cancer _____	_____
Neurologic: Headache, migraine, stroke, TIAs, seizure _____	_____
Psychiatric: _____	_____
Endocrine: Diabetes, thyroid disease _____	_____
Hematologic: Anemia, bleeding disorder, sickle cell disease _____	_____
Allergic/immunologic: Allergies, hay fever, autoimmune disorder _____	_____
Cancer _____	_____

Other comments or problems: _____
_____

EARC 11.10 Patient or Parent Signature: _____ M.D. Initial ____