

Medical History Form v.11.01 – Adult
The Ear Center of Greensboro, P.A., 1126 N. Church St., #201, Greensboro, NC 27401

Patient Name: _____ Age _____ 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 any _____

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 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

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 _____