

History Form: The Ear Center of Greensboro, P.A.

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 01.3 Patient or Parent Signature: _____ M.D. Initial _____