Ear Consultants of Georgia
Medical History Information

Patient Name _____ Date _____

Birthdate _____

Reason for Visit today _____

_____

Current Medications: _____

_____

Are you **allergic** to any medications? If so, please list. _____

_____

Please list any childhood illnesses. _____

_____

Medical Illnesses: (please check the following)

Asthma	_____	Cancer	_____	If yes, what type? _____
Clotting Disorder	_____	Hepatitis	_____	
Diabetes	_____	Seizures	_____	
Heart Disease	_____	Stroke	_____	
High Blood Press.	_____	Tuberculosis	_____	
HIV	_____	Other (please list):	_____	

Ear History: (please check what applies)

	Right	Left		Right	Left
Hearing Loss	_____	_____	Ear Pain	_____	_____
Tinnitus (head noises)	_____	_____	Pressure	_____	_____
Infection	_____	_____	Hearing Aid	_____	_____

Vertigo	_____ Yes	_____ No	
Dizziness/imbalance	_____ Yes	_____ No	
Ear Surgery	_____ Yes	_____ No	Please list below type of ear surgery and dates.

_____

_____

Please list any other surgery and dates: _____

_____

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Review of Systems: (please circle any symptoms that you have had **recently** or are currently experiencing)

Constitutional: severe fatigue fever chills loss of appetite unexplained weight loss or weight gain night sweats

HEENT: blurred vision blindness double vision nosebleeds loss of smell sore throat hoarseness

Cardiac: chest pain palpitations passing out heart murmur swelling in hands or feet

Pulmonary: shortness of breath cough wheezing coughing blood or phlegm

Gastrointest.: abdominal pain nausea vomiting heartburn constipation diarrhea dark tarry stool or blood in stool

Urinary: pain or burning on urination blood in urine frequency or urgency uncontrollable

Neurological: severe headaches loss of coordination numbness or tingling paralysis

Endocrine: hair loss thinning or thickened hair or skin excessive thirst frequently cold or hot

Hematologic: easy bruising bleeding gums persistent bleeding with minor cuts

Height:_____ Weight:_____

Social History: (please circle all that apply)

Do you drink alcohol? Yes No If yes, how much?_____
Do you smoke? Yes No If yes, how much?_____
Quit smoking? Yes No If yes, how long smoked?_____how much?_____
Chew Tobacco? Yes No If yes, how often?_____
Recreational drugs? Yes No If yes, what and how often?_____

Family History: (please check all that apply)

	Family member with disorder:				
	Mother	father	sibling	other	
Asthma	_____	_____	_____	____	specify:
Clotting disorder	_____	_____	_____	____	
Diabetes	_____	_____	_____	____	
Glomus tumor in ear or neck	_____	_____	_____	____	
Heart Disease	_____	_____	_____	_____	
High Blood Pressure	_____	_____	_____	_____	
HIV	_____	_____	_____	_____	
Cancer	_____	_____	_____	_____	
Malignant Hyperthermia	_____	_____	_____	_____	
Seizure disorder	_____	_____	_____	_____	
Stroke	_____	_____	_____	_____	
Thyroid tumors	_____	_____	_____	_____	
Tuberculosis	_____	_____	_____	_____	

Other (please specify):_____