Florida Ear and Balance Center, PA

Initial Visit

Patient Name:_____________________________________Chart #___________________ DOB:____/____/_____

Please provide the following medical information to the best of your ability:

Date:	Age:	List any Allergies to Medications:
What is the reason for your visit today?		

Past Medical History:

1. Please circle the "Yes" or "No" to indicate if you have any of the following illnesses, if 'Yes" please explain

Diabetes	Yes/No	Stomach or Intestinal problems	Yes/No
Hypertension(high blood pressure)	Yes/No	Allergy problems/therapy	Yes/No
Thyroid problems	Yes/No	Kidney problems	Yes/No
Heart Disease/Cholesterol high	Yes/No	Neurological problems	Yes/No
Respiratory problems	Yes/No	Immune deficiency	Yes/No
Bleeding Disorder	Yes/No	Other Medical Diagnosis	Yes/No
Hepatitis	Yes/No	History of IV antibiotic treatment	Yes/No

2. Please list any operations and date of the procedures (including tonsils & adenoids):

3. Please list any current medications (and amounts, times per day);
(including aspirin, antacids, vitamins, hormone replacement, birth control, herbal & weight control supplements,
OTC nasal sprays/cold/sinus/allergy mods)

Social History:		Please list details below:
Do you currently smoke? List how much	Yes/No	
If not smoking now, did you smoke previously?	Yes/No	
How often do you drink alcohol? What kind?	Yes/No	
What is your occupation?	Yes/No	
Do you have a history of cancer?	Yes/No	
Are you routinely exposed to loud noises?	Yes/No	
Are you occasionally exposed to loud noises?	Yes/No	
Have you been exposed to loud noises in the past?	Yes/No	

Family History:

Please circle "Yes" or "No" to indicate whether any relatives have any of the following illnesses:

If yes, please indicate which relative(s) have the problem

Hearing Problems	Yes/No		Heart problems	Yes/No	
Dizziness	Yes/No		Bleeding disorder	Yes/No	
Neurological disorder	Yes/No		Cancer	Yes/No	
Diabetes	Yes/No		Anesthesia problems	Yes/No	
Allergy	Yes/No				

	Reviewed By:

Initial Visit

Patient Name:______________________________________Chart #____________________ Date:____/____/_____

Review of Systems:

1) **Please circle "Yes" or "No" to indicate whether you presently have any of the following symptoms:**
2) **For any "Yes" responses, please check the "current" box if this symptom relates to the reason for your visit today.**

	Yes	No	Current		Yes	No	Current
General: chills				weight loss or gain			
fatigue				daytime sleepiness			
Allergy: enviro allergy				sneezing fits			
post-nasal drip							
Neuro: headache				facial weakness			
passing out				arm or leg weakness			
double vision				arm or numbness			
Eyes: eye pain/pressure				vision changes			
watery or itchy eyes				do you wear glasses			
ENT: ear pain or itch				ear drainage			
hearing loss				ear noises			
dizziness				lightheadedness			
nasal congestion				sinus pressure or pain			
sense of smell problem				problem snoring, apnea			
hoarseness				throat pain			
throat clearing				throat dryness/itching			
Respir. cough				coughing blood			
wheezing				shortness of breath			
Cardiac : chest pain				palpitations			
GI: difficulty swallowing				heartburn			
GU: frequent urination				blood in urine			
Heme/Lym: swollen glands				sweating at night			
bleeding problems				easy bruising			
Endo:feel warmer than others				feel cooler than others			
MSK: joint aches				muscle aches			
Skin: rash				hives			
inching				skin or hair changes			
Psych: depression				anxiety or panic			

PLEASE STOP HERE

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Reviewed by: