Ohio Ear Institute, LLC
387 County Line Road West
Suite 115
Westerville, OH 43082

614 891 9190

PATIENT HEALTH HISTORY

Patient Name:_____ Date of Birth: _____

CHIEF CONCERN

Reason for today's visit: _____

PAST MEDICAL HISTORY

Please list any prior major illnesses and/or injuries: _____

_____

_____

SURGERIES/HOSPITALIZATIONS	YEAR

MEDICATIONS (List Name, dosage and frequency)

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Are you allergic to any medications? No ___ Yes ___ If yes please list: _____

FAMILY HISTORY

(In particular please list family members with a history of hearing loss, dizziness, migraine or acoustic tumor)

Family member	Medical problems

SOCIAL HISTORY

Occupation: _____

History of smoking?: No ___Yes____ If yes, what type, packs per day, and for how long? _____

History of alcohol use?: No ___Yes___If yes, how often? _____

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REVIEW OF SYSTEMS (Please circle all items that you have had problems with)

Constitutional
Fever
Weight Loss
Excessive Fatigue
Night Sweats

Eyes
Wear glasses/contacts
Infections
Injury
Glaucoma
Cataracts

Ear, Nose, Throat & Mouth
Wear Hearing Aid
(Date of last exam _____)
Hearing Loss
Ear Pain
Ear Infection
Ringing in the Ear(s):
Left ____ Right _____Both ____
Balance Disturbance:
Vertigo _____
Spinning _____
Unsteadiness_____
Floating Sensation____
Lightheadedness_____
Nosebleeds
Nasal Congestion
Nasal Drainage
Inability to Smell
Sinus Problem
Sinus Headaches
Sore Throat
Mouth Sores

Cardiovascular
Chest pain or angina
High Blood Pressure
Irregular Pulse
Heart Murmur
High Cholesterol
Swelling in Feet and Hands
Leg Pain/Cramping While Walking

Respiratory
Asthma
Chronic Cough
Emphysema
Shortness of Breath
Bronchitis
Pneumonia
Lung Cancer
Bloody Sputum

Gastrointestinal
Indigestion and Pain with Eating
Nausea
Vomiting
Blood in Vomit
Liver Disease
Jaundice
Abdominal Pain
Change in Bowel Habits
Ulcers or Gastritis
Colon Cancer

Genitourinary
Urinary Tract Infection
Painful Urination
Blood in your Urine
Difficulty Starting/Stopping Stream
Incontinence
Kidney Stones
Prostate Cancer
Endometriosis
Uterine or Cervical Cancer

Musculoskeletal
Broken Bones
Arm or Leg Weakness
Back Pain
Arm or Leg Pain
Joint pain or Swelling
Arthritis

Integumentary
Skin Disease
Skin Cancer
Breast Pain, Tenderness or Swelling
Nipple Discharge

Neurological
Fainting Spells or Blackouts
Seizures
Strokes
Migraine Headaches
Problems with Memory
Disorientation
Difficulty with Speech
Inability to Concentrate
Double or Blurred Vision
Face Weakness
Coordination in Arms and/or Legs
Psychiatric
Anxiety/Depression
Other Psychiatric Disorder:
_____

Endocrine
Diabetes
Thyroid Disease
Increased Appetite
Excessive Thirst or Urination
Hormone Problems

Hematologic/Lymphatic
Anemia
Hemophilia
Bleeding Tendency
Persistent Swollen Glands or Lymph Nodes
Blood Transfusion
Date: _____

Allergic/Immunologic:
Food Allergies
Inhalant (nasal) Allergies
Immunologic Disorder:_____

The above information is accurate to the best of my knowledge:
Patient (or Guardian) Signature: _____Date: _____

The above information has been reviewed with the patient and is deemed correct:

Physician: _____Date: _____

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